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PLACE OF DEATH

Saffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

STANDARD  
CERTIFICATE OF DEATH

Registered No. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sarah L. Bird

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 88 Gladstone St

(Usual place of abode)

East Boston, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, 10 years, months, days. In place of residence, 25 years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN - 4 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 5 1960, to JAN 4 1964

I last saw him alive on JAN 4 1964, death is said to have occurred on the date stated above, at 10:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia, Bilateral

Due To heart failure - Heart Block

(b) DIABETES MELLITUS, ARTERIOSCLEROSIS

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) S. Guy GRANDJEAN M. D.

20 JANA REGA ST E. Boston

(Address) (Print or Type Name) Date 1-4-64

6 Rural Cemetery New Bedford Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 6 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

Winthrop, Mass.

ADDRESS

Received and filed JAN 6 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 99 Years 3 Months 1 Days If under 24 hours Hours Minutes

13 Usual Occupation: School Teacher (Kind of work done during most working life)

14 Industry or Business: Public school

15 Social Security No. none

16 BIRTHPLACE (City) Bridgewater (State or country) Mass.

17 NAME OF FATHER William E Bird

18 BIRTHPLACE OF FATHER (City) Wrentham (State or country) Mass.

19 MAIDEN NAME OF MOTHER Eliza Tobey

20 BIRTHPLACE OF MOTHER (City) New Bedford (State or country) Mass.

21 Informant William Bird

(Address) North Conway New Hampshire

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scrammi (S)

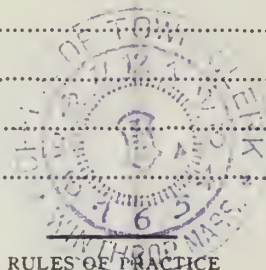
(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

January 6 1964 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE..... ASSIGNED.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop, Mass

(City or Town)

Winthrop Community Hospital

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

STANDARD

CERTIFICATE OF DEATH

Registered No.

2

Daniel Lyons

PHYSICIAN — IMPORTANT

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

117 Shore Drive

(a) Residence, No.

(Usual place of abode)

St. WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence: 5 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN 5 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1/4 1964 to 1/5 1964

I last saw him live on 1/5 1964, death is said to have occurred on the date stated above, at 555P M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS CHRONIC PYELONEPHRITIS ARTERIO-SCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH 2 DAYS

Was autopsy performed? YES

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) MYRON N. KING M. D.  
MYRON N. KING M. D.

(Address) WINTHROP MASS Date 1/6 1964

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 7 1964

7 NAME OF FUNERAL DIRECTOR MARILYN W. KIRBY  
210 WINTHROP ST

ADDRESS WINTHROP

Received and filed JAN 6 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN SINGLE

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation SEAMAN (Kind of work done during most working life)

14 Industry or Business U S MERCHANT MARINE

15 Social Security No.

16 BIRTHPLACE (City) BOSTON (State or country) MASS

17 NAME OF FATHER MICHAEL LYONS

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER CASSAIE COOGAN

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

21 Informant (Address) MISS. EMILY LYONS

117 SHORE DRIVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan

(Signature of Agent of Board of Health or other)

Health Officer

January 6, 1964 (Date of Issue of Permit)

A TRUE COPY ATTEST:

VLLV

MEDICAL EXAMINER DECLINED JURISDICTION

FORM R-301

led for burial permit Board of Health or its Agent.

INSTRUCTIONS FOR JUDICIAL CERTIFICATE

NT OR TYPE E OR CAUSES F DEATH

o not enter ore than one use for each i), (b) and (c)

does not mean ode of dying, is heart failure, a, etc. It means ease, or compli- which caused

ditions, if any, h gave rise to e cause (a), ng the under- cause last.

ditions contrib- to death but not to the terminal condition given

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

763  
JAN - 6 1964 PM  
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



# The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD CERTIFICATE OF DEATH

Registered No. 3

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 111 Sunnyside Ave.

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Robert Crofton Leased  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran, 10  
if so specify WAR)

(a) Residence, No. 111 Sunnyside Ave.  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 10 years months days. In place of residence 50 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January - 6 - 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19 to 19

I last saw him alive on 19, death is said to  
have occurred on the date stated above, at 6:50 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Presumably  
Coronary Occlusion

Due To Death Apparently due  
(b) to Natural Causes

Due To Signed for the  
(c) Winthrop Board of Health

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Clinical History

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) John F. Collins M.D.  
(PRINT OR TYPE SIGNATURE)

(Address) Revere Mass Date 7 Jan 1964

6 Place of Burial or Cremation (City or Town)  
DATE OF BURIAL Jan 8 1964

7 NAME OF FUNERAL DIRECTOR No. rd 111 Nord  
ADDRESS

Received and filed JAN 8 1964 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED married

10a If married, widowed, or divorced:  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years 1 Months 21 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Estimator  
(Kind of work done during most of working life)

14 Industry or Business: State 1 Co

15 Social Security No. 04-09-3014

16 BIRTHPLACE (City) South Brookfield  
(State or country) Nova Scotia

17 NAME OF FATHER Crofton, Robert

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Catherine Smith

20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country)

21 Informant (Address) Dr. J. M. Leased

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)  
Health Officer January 8, 1964  
(Official Designation) (Date of Issue of Permit)

M R-301A

INSTRUCTIONS  
FOR  
L CERTIFICATE

giving  
OF DEATH

not enter  
e than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
ise, or compli-  
which caused

ions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
a the terminal  
condition given

Chapter 137,  
1954, requires  
ns to print or  
le cause or  
e of death on  
rtificates, and  
48, Acts of  
quires Physi-  
print or type  
der signature.

6-59-925686

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



and for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

CAUSE OR TYPE  
OF CAUSES  
OF DEATH

not enter  
more than one  
cause for each  
(a), (b) and (c)

does not mean  
mode of dying,  
heart failure,  
etc. It means  
cause, or compli-  
cation which caused

conditions, if any,  
gave rise to  
cause (a),  
or the under-  
cause last.

conditions contrib-  
uted to death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 4

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

No. 65 Cottage Park Road

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME Mary L. Garvey  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 65 Cottage Park Road St.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 8 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
Nov. 23, 1963, to Jan. 8, 1964.  
I last saw her live on January 8, 1964 death is said to  
have occurred on the date stated above, at 1:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized carcinomatosis 2 mos  
Due To (b) Carcinoma head of pancreas 6 to 8 mos  
Due To (c) Left inguinal hernia 10 yrs

OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis 5 yrs

Was autopsy performed? no  
What test confirmed diagnosis: Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased NO  
If so, specify

(Signature) M. Traunstein, Jr. M. D.  
(Print or Type Name)  
(Address) 73 Bartlett Rd. Winthrop, Mass. Date Jan. 8, 1964

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 11, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J O'Maley

ADDRESS Winthrop Mass

Received and filed JAN 10 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Joseph F. Garvey  
(Husband's name in full)

12 AGE 84 Years.....Months.....Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Boston  
(State or country) Mass

17 NAME OF FATHER Edward Cummings

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER Catherine Brown

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

21 Informant (Address) Ruth Garvey  
65 Cottage Park Road

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)  
(Official Designation) (Date of Issue of Permit) Jan 9, 1964

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



JAN 1 10 1964 AM

For burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
VITAL CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
se for each  
, (b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
ase, or compli-  
which caused

tions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
to the terminal  
condition given

X  
PLACE OF DEATH

Suffolk

(County)

Winthrop, Mass

(City or Town)

Winthrop Community Hospital

No.

Albert E. Keleher

2 FULL NAME.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

3 Woodside Park

(a) Residence, No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months<sup>1</sup>.....days. In place of residence.....40.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 9 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 62, to Jan 9 1964

I last saw him live on Jan 9 1964 death is said to have occurred on the date stated above, at 8:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bleeding carcinoma stomach 6 hours

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS Aneurysm abdominal aorta

Was autopsy performed? No

What test confirmed diagnosis? X-Ray

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) H. B. Greenfield, M. D.

H. B. Greenfield  
(Print or Type Name)

(Address) Winthrop Mass Date Jan 9 1964

6 Holyhood Cemetery Brookline Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 13 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 10 1964 19

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

## CERTIFICATE OF DEATH

Registered No. 5

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

## PHYSICIAN - IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) no

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Divorced UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of Cora Weise  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Salesman  
(Kind of work done during most working life)

14 Industry or Business Paper Products

15 Social Security No. 024-03-0479

16 BIRTHPLACE (City) Boston Mass  
(State or country)

17 NAME OF FATHER James B. Keleher

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER Julia Donahue

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)21 Informant Cora Keleher  
(Address) 3 Woodside Park, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Sirisano  
(Signature of Agent of Board of Health or other)  
Health Officer January 10, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JAN 1 0 1964 PM



PLACE OF DEATH

~~Winthrop~~ Suffolk

(County)

Winthrop

(City or Town)

No. ~~Mount's Rest Home~~ Nursing

## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No. ....

6

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
{ if so specify WAR) No

2 FULL NAME..... Michael White  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 93 Bellingham Avenue  
(Usual place of abode)

St. Revere  
(If nonresident, give city or town and State)

Length of stay: In place of death..... years..... 2 months..... days. In place of residence..... 36 years..... months..... days.

INSTRUCTIONS  
FOR  
CERTIFICATE

giving  
OF DEATH

not enter  
than one  
for each  
(b) and (c)

does not mean  
of dying,  
heart failure,  
etc. It means  
or compli-  
which caused

ons, if any,  
have rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
the terminal  
condition given

Chapter 137,  
954, requires  
to print or  
e cause or  
if death on  
ificates, and  
48, Acts of  
quires Physi-  
print or type  
er signature.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 13, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
Feb 1963 to Jan 13, 1964  
I last saw him alive on Jan 13, 1964, death is said to  
have occurred on the date stated above, at 9:50 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Prostate

Due To Metastatic Carcinoma  
(b) from above to  
bones, liver, and lungs.

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS None.

Was autopsy performed?

What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signed) Charles Liberman, M. D.

CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 1/13/1964

6 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 17, 1964

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella  
ADDRESS 876 Winthrop Ave., Revere

Received and filed JAN 15 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed or divorced  
HUSBAND of Nellie Doyle  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years..... Months..... Days If under 24 hours  
..... Hours..... Minutes

13 Usual Occupation: Retired-  
(Kind of work done during most of working life)

14 Industry or Business: Iron Worker

15 Social Security No. 028-09-4903 A

16 BIRTHPLACE (City)  
(State or country) Newfoundland

17 NAME OF FATHER Michael White

18 BIRTHPLACE OF FATHER (City)  
(State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Susan not known

20 BIRTHPLACE OF MOTHER (City)  
(State or country) Newfoundland

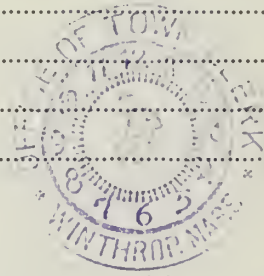
21 Informant Mrs. Gerald White  
(Address) 287 Revere St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranni (B)  
(Signature of Agent of Board of Health or other)

Health Officer January 15, 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease or injury related to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.STANDARD  
CERTIFICATE OF DEATH

Registered No. 7

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 41 Buckthorn Terrace

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{ (Was deceased a  
U. S. War Veteran,  
if so specify WAR)

2 FULL NAME Leah Frances (Simmons) Stainforth

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 41 Buckthorn Terrace  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 15 years 68 months 19 days. In place of residence 4 years 19 months 19 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 14, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Dec. 9, 1963, to January 14, 1964.I last saw her alive on January 13, 1964, death is said to  
have occurred on the date stated above, at 4 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral hemorrhage

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

4 hrs

(b) Due To Arteriosclerotic and  
hypertensive heart disease

5 yrs

(c) Due To Generalized arteriosclerosis

7 yrs

OTHER SIGNIFICANT CONDITIONS Diabetes mellitus,  
severe

5 yrs.

Was autopsy performed? no

What test confirmed diagnosis? Clinical &amp; laboratory

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Signed) M. Traunstein, Jr., M. D.

M. Traunstein, Jr., M. D.

(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Jan. 14, 1964

6 Woodlawn Crematory Everett, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 16, 1964

7 NAME OF FUNERAL DIRECTOR Howard E. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JAN 15 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED Married10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Frederick A. Stainforth  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 60 Years 4 Months 19 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 025-01-2451

16 BIRTHPLACE (City) Winthrop  
(State or country) Mass.

17 NAME OF FATHER Alfred Simmons

18 BIRTHPLACE OF FATHER (City) England  
(State or country)

19 MAIDEN NAME OF MOTHER Cadie Merrit

20 BIRTHPLACE OF MOTHER (City) Norwell  
(State or country) Mass.21 Informant Frederick A. Stainforth  
(Address) 41 Buckthorn Terr. WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Raech E. Simmons (B)  
(Signature of Agent of Board of Health or other)Health Officer January 15, 1964  
(Official Designation) (Date of Issue of Permit)

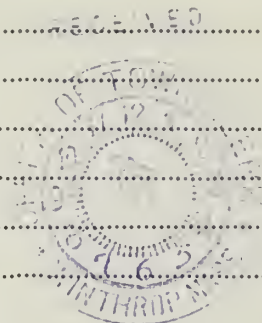
V13V

R-301A

INSTRUCTIONS  
FOR  
CERTIFICATEgiving  
OF DEATHnot enter  
than one  
for each  
(b) and (c)does not mean  
of dying,  
heart failure,  
etc. It means  
e, or compli-  
which causedons, if any,  
have rise to  
because (a),  
the under-  
cause last.ations contrib-  
death but not  
the terminal  
condition givenChapter 137,  
1954, requires  
s to print or  
s cause or  
of death on  
ificates, and  
48, Acts of  
quires Physi-  
print or type  
er signature.



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.STANDARD  
CERTIFICATE OF DEATH

Registered No. 8

PLACE OF DEATH

SUFFOLK  
(County)WINTHROP  
(City or Town)

No. BAY VIEW NURSING HOME

{(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME OLIVE K. DONALDSON

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Residence. No. 25 Locust  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 5 years 10 months 11 days. In place of residence 40 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 16, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
MARCH 5, 1958 to JANUARY 16, 1964  
I last saw her alive on JANUARY 16, 1964, death is said to  
have occurred on the date stated above, at 10:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BILATERAL BRONCHO-  
PNEUMONIAINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
2 daysDue To  
(b)Due To  
(c)OTHER SIGNIFICANT CONDITIONS  
ARTERIOSCLEROTIC HEART D.S. 6 YRS.  
GENERALIZED ARTERIOSCLEROSIS 10 YRS

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL &amp; LABORATORY

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signed) M. Traunstein Jr., M.D.

M. TRAUNSTEIN JR., M.D.  
(PRINT OR TYPE SIGNATURE)

(Address) 73 BARTLETT RD. Date JAN 16, 1964

6 Wadsworth Elm. Everett Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 18, 1964

7 NAME OF FUNERAL DIRECTOR Charles E. D. Mangeson Jr.

ADDRESS 839 Main St. Malden, Mass.

Received and filed JAN 17 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED Single  
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation: At Home - house keeping  
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) Worcester  
(State or country) Mass.

17 NAME OF FATHER Lchabod Donaldson MD

18 BIRTHPLACE OF FATHER (City) Bombay  
(State or country) New York

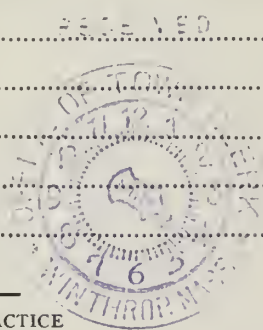
19 MAIDEN NAME OF MOTHER Francis Holt

20 BIRTHPLACE OF MOTHER (City) London  
(State or country) New Hampshire21 Informant Charles E. D. Mangeson Jr.  
(Address) 839 Main St. MaldenI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph G. Mangeson Jr.  
(Signature of Agent of Board of Health or other)Health Officer 1-17-64  
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS  
FOR  
CERTIFICATEgiving  
OF DEATHnot enter  
than one  
for each  
(b) and (c)does not mean  
of dying,  
heart failure,  
etc. It means  
e, or compli-  
which causedns, if any,  
ave rise to  
cause (a),  
the under-  
cause last.tions contrib-  
death but not  
the terminal  
condition givenChapter 137,  
1954, requires  
s to print or  
cause or  
f death on  
ificates, and  
48, Acts of  
quires Physi-  
print or type  
er signature.

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts  
JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Melrose

(City or town making return)

Registered No. 9

Middlesex  
(County)

Melrose

(City or Town)



COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

No. 33 Ridgewood Lane

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME John Gustavson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No(a) Residence. No. 1 Burrill Terrace  
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. years months 1 days. In place of residence. 35 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 17, 1964

(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)Heart Disease - presumably  
Coronary Sclerosis  
(sudden death)

5 Accident, suicide, or homicide (specify) no

Date and hour of injury 19.

If accidental, was injury causally related to the death?

Where did

Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place?

(Specify type of place)

Manner of

Injury (How did injury occur?)

Nature of

Injury

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Thomas P. Devlin M. D.  
(Address) Stoneham, Mass. Date Jan. 17, 1964

7 Winthrop Winthrop, Mass.

Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL January 21, 1964

8 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed JAN 31 1964 19

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Male

10 COLOR

White

11 SINGLE (write the word)

MARRIED Married  
WIDOWED  
or DIVORCED

11a If married, widowed, or divorced

HUSBAND of Anna Larsen

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE 65 Years 7 Months 4 Days

If under 24 hours

Hours Minutes

14 Usual

Occupation: Painter

(Kind of work done during most of working life)

15 Industry

or Business: Contractor

16 Social Security No.

025-01-8995

17 BIRTHPLACE (City)

(State or country)

Unable to obtain  
Sweden

18 NAME OF FATHER

Gustav Johanson

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Unable to obtain  
Sweden

20 MAIDEN NAME

OF MOTHER

Gerda (unable to obtain)

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Unable to obtain  
Sweden

22

Informant Anna Gustavson

(Address) 1 Burrill Terrace, Winthrop, Mass.

A TRUE COPY.

ATTEST: Raymond H. Greenbaum  
(Registrar of City or Town where death occurred)

DATE FILED January 21, 1964

19

V.P. ✓

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



RECEIVED



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE ..... JAN 31 1964 AM

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

For burial permit  
of Health  
Agent.

CTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

ot enter  
than one  
for each  
(b) and (c)

es not mean  
of dying,  
heart failure,  
etc. It means  
e, or compli-  
which caused

ns, if any,  
ave rise to  
ause (a),  
the under-  
ause last.

tions contrib-  
death but not  
the terminal  
ndition given

PLACE OF DEATH

SUFFOLK  
(County)

WINTHROP  
(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 10

No. MAY FLOWER NURSING HOME  
39 GROVER AVE

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME AUGUSTA L. SKINNER  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR.)

(a) Residence, 1079 SHIRLEY ST.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 10 years.....months.....days. In place of residence 29 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 17 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
SEPT. 16, 1952, to JAN. 17, 1964

I last saw her on JAN. 14, 1964, death is said to  
have occurred on the date stated above, at 2:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 days

Due To ARTERIOSCLEROTIC + HYPERTENSIVE  
(b) HEART DISEASE

12 YRS

Due To GENERALIZED ARTERIO-  
(c) SCLEROSIS

14 YRS

OTHER  
SIGNIFICANT  
CONDITIONS NONE

Was autopsy performed? No  
What test confirmed diagnosis? CLINICAL + LAB.

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) M. Traubstein Jr. M. D.  
M. TRAUBSTEIN JR. M.D.

(Address) 73 BARTLETT RD. WINTHROP, MASS. (Date) JAN 17 1964

6 WOODLAWN EVERETT  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN. 20, 1964

7 NAME OF FUNERAL DIRECTOR Wendell M. Dylman

ADDRESS 23 Cary Ave. Chelsea

Received and filed JAN 17 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN WIDOW

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of FRANK SKINNER  
(Husband's name in full)

12 MARCH 12, 1872 If under 24 hours  
AGE 91 Years 10 Months 5 Days Hours Minutes

13 Usual Occupation: RETIRED HOUSEKEEPER  
(Kind of work done during most working life)

14 Industry or Business: PRIVATE HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) MIAMI FLA.  
(State or country) N.S.

17 NAME OF FATHER EDWARD LYDIARD

18 BIRTHPLACE OF FATHER (City) NOVA SCOTIA  
(State or country)

19 MAIDEN NAME OF MOTHER ELLEN KEENE

20 BIRTHPLACE OF MOTHER (City) NOVA SCOTIA  
(State or country)

21 Informant FREDERICK NEAL  
(Address) 4794 SO. W. 82<sup>ND</sup> ST. MIAMI FLA.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranni (R)  
(Signature of Agent of Board of Health or other)

Health Officer January 17, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

JAN 17 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
for each  
(b) and (c)

does not mean  
of dying,  
heart failure,  
etc. It means  
ie, or compli-  
which caused

ons, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

physicians contrib-  
death but not  
the terminal  
condition given

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 11

PLACE OF DEATH

SUFFOLK  
(County)

WINTHROP  
(City or Town)

No. 156 PAULINE ST

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GEORGE DERLIN  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) WWI

(a) Residence. No. 156 PAULINE  
(Usual place of abode)

St. WINTHROP  
(City or town and State)

Length of stay: In place of death 16 years months days. In place of residence 63 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19 to 19

I last saw him alive on 19, death is said to  
have occurred on the date stated above, at 2:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1 hr

(b) Due To Death immediately due to

(c) Due To natural causes

OTHER SIGNIFICANT CONDITIONS  
Winthrop Board of Health

Was autopsy performed?  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) John F. Collins M.D.

(Print or Type Name)

(Address) 27 Conant Street Date Jan 21, 1964

6 HOLY HOOD BROOKLINE  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 23 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. MIRBY

ADDRESS WINTHROP, MASS.

Received and filed JAN 21 1964 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)  
MALE WHITE MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN MARRIED

11 If married, widowed, or divorced  
HUSBAND of IRENE BARTER  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 63 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation DESIGNER  
(Kind of work done during most of working life)

14 Industry or Business MACHINERY

15 Social Security No. 027-07-5117

16 BIRTHPLACE (City) WINTHROP  
(State or country) MASS

17 NAME OF FATHER SAMUEL DERLIN

18 BIRTHPLACE OF FATHER (City) IRELAND  
(State or country)

19 MAIDEN NAME OF MOTHER CATHERINE KELLY

20 BIRTHPLACE OF MOTHER (City) NOVA SCOTIA  
(State or country)

21 Informant IRENE DERLIN

(Address) 156 PAULINE ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Scramm B.  
(Signature of Agent of Board of Health or other)

Health officer Jan 21, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

VIB V

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....SEPT 3 1918.....

DATE OF DISCHARGE.....SEPT 30 1921.....

RANK, RATING.....APPRENTICE SEAMAN.....

ORGANIZATION AND OUTFIT.....U S NAVAL RESERVE.....

SERVICE NUMBER.....200-04-57.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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JAN 21 1964 PM

For burial permit  
and of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

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for each  
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heart failure,  
etc. It means  
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The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 12

PLACE OF DEATH

WINTHROP  
(County)

WINTHROP  
(City or Town)

No. BAY VIEW NURSING HOME STURGIS

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNE MOHR  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

(a) Residence. No. 974 SARATOGA  
(Usual place of abode)

St. EAST BOSTON  
(City or town and State)

Length of stay: In place of death.....years.....months.....3 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 20 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Jan. 16, 1964, to Jan. 20, 1964.

I last saw her alive on Jan. 19, 1964, death is said to  
have occurred on the date stated above, at 10:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Gastroenteritis

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

Due To (b) Virus Infection 4 days

Due To (c)

OTHER SIGNIFICANT CONDITIONS Os. Nasalis 3 days

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles J. Finner, M. D.  
(Print or Type Name)

(Address) 1545 Lexington St. Date 1/22 1964

6 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 23 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP, MASS.

Received and filed JAN 23 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN SINGLE

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGED 5 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation ELBOCUTION TEACHER - RETIRED (Kind of work done during most of working life)

14 Industry or Business SCHOOL

15 Social Security No. NONE

16 BIRTHPLACE (City) RICHMOND (State or country) VA.

17 NAME OF FATHER HENRY MOHR

18 BIRTHPLACE OF FATHER (City) GERMANY (State or country)

19 MAIDEN NAME OF MOTHER ANNE MCNEIL

20 BIRTHPLACE OF MOTHER (City) ST. JOHN (State or country) N.B.

21 Informant MRS CLAUDIA SILINSKY

(Address) QUINCY, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer (Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

---

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit  
ard of Health  
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FOR  
CERTIFICATE

OR TYPE  
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for each  
(b) and (c)

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heart failure,  
etc. It means  
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the terminal  
ndition given

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **13**

1

PLACE OF DEATH

**SUFFOLK**

(County)

**WINTHROP**

(City or Town)

No. **33 SUNNYSIDE AVE**

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME

**ELLA (LA VOIX) BOUTIN**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO**

(a) Residence. No.

**33 SUNNYSIDE AVE**

St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death **70** years.....months.....days. In place of residence **70** years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH

**Jan 30 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

**JAN 27, 1964, to JAN 30, 1964**

I last saw her alive on **JAN 30, 1964**, death is said to

have occurred on the date stated above, at **7:30 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral Hemorrhage**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**4 days**

Due To **Arteriosclerosis cerebri**

(b) **Arteriosclerosis cerebri**

**3 yrs.**

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

**None**

Was autopsy performed?

**NO**

What test confirmed diagnosis **clinical**

5 Was disease or injury in any way related to occupation of deceased **NO**  
If so, specify

(Signature) **Charles Liberman** M. D.

**CHARLES LIBERMAN**

(Print or Type Name)

(Address) **WINTHROP, MASS** Date **1/31/64**

6 **HOLY CROSS**

Place of Burial or Cremation

**MALDEN**

(City or Town)

DATE OF BURIAL **FEB 1**

**1964**

7 NAME OF

FUNERAL DIRECTOR

**MAURILE W. KIRBY**

ADDRESS **WINTHROP**

Received and filed

**JAN 31 1964**

19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX

**FEMALE**

9 COLOR

**WHITE**

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

**WIDOWED**

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of **GERARD BOUTIN**

(Husband's name in full)

12

AGE

**91** Years.....Months.....Days

If under 24 hours

.....Hours.....Minutes

13

Usual

Occupation

**HOME MAKER (RETIRED)**

(Kind of work done during most of working life)

14

Industry

or Business

**HOME**

15

Social Security No.

**NONE**

16

BIRTHPLACE (City)

**CHELSEA**

(State or country)

**MASS**

17

NAME OF

FATHER

FATHER

(City)

(State or country)

19

MAIDEN NAME

OF MOTHER

MOTHER

(City)

(State or country)

20

BIRTHPLACE OF

MOTHER

(City)

(State or country)

21

Informant

**MRS LOUISE ROSETTI**

(Address)

**33 SUNNYSIDE AVE WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph B. Giovanni**

(Signature of Agent of Board of Health or other)

**Health Officer**

(Official Designation)

**January 31, 1964**

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

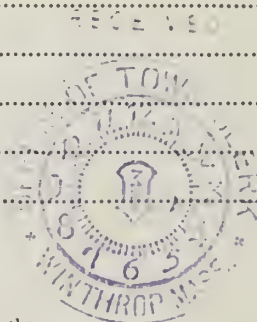
DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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A TRUE COPY ATTEST:

*William J. Kane.*

A TRUE COPY ATTEST:

*William J. Kane.*

A TRUE COPY ATTEST:

*William J. Kane.*  
City, Registrar



FEB 28 1964 AM

d for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
A CERTIFICATE

Ng Book-Proc-1-

Washington Ave

T OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
use, or compli-  
which caused.

ions, if any,  
gave rise to  
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ditions contrib-  
death but not  
to the terminal  
condition given

+ 20.1  
81  
x 70

28 1964

252-934553

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

15

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 00159

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

No. New England Center Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)~~Grace Madeleine Pettindell Field~~

PHYSICIAN — IMPORTANT

2 FULL NAME

Grace Pettingell

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

NO.

26 Sturgis Street, Winthrop, Mass.

(a) Residence, No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death.....years.....months.....4 days. In place of residence 45 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 5 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from  
January 1, 1964 to January 5, 1964I last saw her alive on January 5, 1964, death is said to  
have occurred on the date stated above, at 11:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory failure

(b) Due To Respiratory Acidosis

(c) Due To Lobar Pneumonia

OTHER SIGNIFICANT CONDITIONS

Coronary heart disease with atrial fibrillation yrs.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ....  
If so, specify

(Signature) Alan Fisch

Alan Fisch

(Print or Type Name)

(Address) NE CT Date Jan 5 1964

6 Winthrop Cemetery, Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 8, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed

A TRUE COPY ATTEST.

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

female white

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of William H. Pettingell

(Husband's name in full)

12

AGE 88 years 5 months 4 days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation

housework

(Kind of work done during most of working life)

14 Industry

or Business

own home

15 Social Security No.

011-36-9134

16 BIRTHPLACE (City)

Palmyra

(State or country)

Maine

17 NAME OF

FATHER

Millard Filmore Field

18 BIRTHPLACE OF

FATHER (City)

Palmyra

(State or country)

Maine

19 MAIDEN NAME

OF MOTHER

Louisa Elizabeth Brackett

20 BIRTHPLACE OF

MOTHER (City)

Orono

(State or country)

Brackett

(State or country)

Maine

(State or country)

(State or country)

(State or country)

(State or country)

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(State or country)

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(State or country)

(State or country)

(State or country)

21 Informant

Robert M.E. Field

(Address)

Herring Run, West Harwich

(Address)

(Address)

(Address)

(Address)

(Address)

(Address)

(Address)

(Address)

(Address)

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature)

J. J. J. J.

(Signature of Agent of Board of Health or other)

(Official Designation)

1979

(Date of Issue of Permit)

(Date of Issue of Permit)

(Date of Issue of Permit)

(Date of Issue of Permit)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



FEB 28 1964 AM

For burial permit  
of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
R CAUSES  
EATH

ot enter  
than one  
for each  
b) and (c)

es not mean  
of dying,  
heart failure,  
tc. It means  
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89

28 1964

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

16

(City or Town making this return)

PLACE OF DEATH

SUFFOLK  
(County)BOSTON  
(City or Town)STANDARD  
CERTIFICATE OF DEATH

Registered No. 00160

No. BETH ISRAEL HOSPITAL

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME JOHN<sup>C</sup> BURKE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 134 CIRCUIT RD.  
(Usual place of abode)St. WINTHROP, MASS.  
(City or town and State)

Length of stay: In place of death, years, months, 5 HRS. In place of residence, 39 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 6, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
JAN. 6, 1964, to JAN. 6, 1964I last saw him alive on JAN. 6, 1964, death is said to  
have occurred on the date stated above, at 8:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LOBAR PNEUMONIA

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
3 DAYSDue To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

CONGESTIVE HEART FAILURE

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased NO  
If so, specify

(Signature) Ronald T. Rozett, M. D.

RONALD T. ROZETT

(Address) 330 BROOKLINE AVE. Date JAN. 6, 1964  
BOSTON 15, MASS.6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JANUARY 9, 1964

7 NAME OF FUNERAL DIRECTOR ARTHUR J. O'MALEY

ADDRESS WINTHROP, MASS.

Received and filed

JAN 10 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MALE WHITE

MARRIED

11 If married, widowed or divorced  
HUSBAND of HELENA E EPPS  
(Give maiden name of wife in full)(or) WIFE of  
(Husband's name in full)

12 AGE 67 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: RETIRED ELECTRICIAN  
(Kind of work done during most of working life)

14 Industry or Business: U. S. NAVAL SHIPYARD

15 Social Security No.  
16 BIRTHPLACE (City) CHelsea MASS  
(State or country)

17 NAME OF FATHER JOHN W. BURKE

18 BIRTHPLACE OF FATHER (City) ST. JOHN N. B.  
(State or country)

19 MAIDEN NAME OF MOTHER HENRIETTA JOHNSTON

20 BIRTHPLACE OF MOTHER (City) STOUGHTON MASS  
(State or country)21 Informant HELENA E BURKE  
(Address) 134 CIRCUIT RD WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other)

19989 1/7/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST.

A TRUE COPY ATTEST:

*William Kane.*  
City Registrar



FEB 28 1964 AM



(Official Designation) (Date of Issue of Permit)

RUE ONE NORTH  
*William J. Kane.*  
City Recorder

RECEIVED



FEB 28 1964 AM





A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



FEB 28 1964 AM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50H-6-62-9331014

PLACE OF DEATH

Norfolk  
(County)Wellesley  
(City or Town)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Wellesley

(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 8

No. Wellesley Manor

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

2 FULL NAME Mary McDonald

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)}

(a) Residence. No. 16 Johnson Avenue,  
(Usual place of abode)

St. Winthrop

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 14, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
January, 1963, to January 14, 1964

I last saw her live on January 14, 1964 death is said to  
have occurred on the date stated above, at 3 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Rheumatic Heart Disease

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

40 yrs

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS General Arteriosclerosis

10 yrs

Was autopsy performed? No

What test confirmed diagnosis? X-Rays-Laboratory

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Morris Ringer  
Morris Ringer M.D.

(Address) 851 Beacon St.  
Newton Date 1/14 1964

6 Winthrop Cem., Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 17th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed Feb 18, 1964 19

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED Divorced  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Matthew L. McDonald (Husband's name in full)

12 AGE 82 Years 11 Months 14 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) So. Boston,  
(State or country) Mass.

17 NAME OF FATHER Joseph Shaughnessy

18 BIRTHPLACE OF FATHER (City) Boston,  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Katherine Sullivan

20 BIRTHPLACE OF MOTHER (City) Boston,  
(State or country) Mass.

21 Informant Mrs. Martha J. Gilligan - Dau.

(Address) 12 Edgewater Drive, Wellesley

TRUE COPY

ATTEST: May C. Titus  
(Registrar of City or Town where death occurred)

DATE FILED January 16, 1964

F.B.V.

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

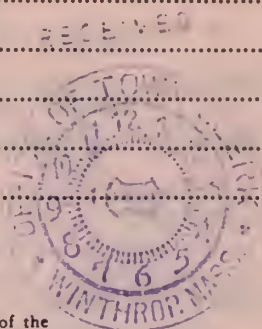
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



FEB 18 1964 PM



for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
for each  
(b) and (c)

does not mean  
of dying,  
heart failure,  
etc. It means  
ie, or compli-  
which caused

ons, if any,  
gave rise to  
cause (a),  
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cause last.

itions contrib-  
death but not  
the terminal  
condition given

MEDICAL EXAMINER DECLINED JURISDICTION.

# The Commonwealth of Massachusetts



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

20

(City or Town making this return)

00580

Registered No.

Suffolk  
(County)

Boston  
(City or Town)

STANDARD

## CERTIFICATE OF DEATH

No. Peter Bent Brigham Hospital

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Robert Reese  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR.)

(a) Residence. No. 275 Court Rd.  
(Usual place of abode)

XX Winthrop, Mass.  
(City or town and State)

Length of stay: In place of death, years, months, 1 day / In place of residence, 50 years, months, days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 16, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Jan. 15, 1964, to Jan. 16, 1964.

We saw him on Jan. 16, 1964, death is said to  
have occurred on the date stated above, at 4:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cirrhosis with gastro-  
intestinal hemorrhage

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) David D. Ulmer, M. D.

David D. Ulmer, M. D.

PBBH (Print or Type Name)

(Address) Date Jan. 16, 1964

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 20 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W MIRBY

ADDRESS 210 WINTHROP ST. WINTHROP.

Received and filed 19

21 JAN 21 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of MARGARET RACIGN  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 57 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation PROP.  
(Kind of work done during most of working life)

14 Industry or Business TRAILER PARKS.

15 Social Security No. 028-05-8275

16 BIRTHPLACE (City) BOSTON  
(State or country) MASS

17 NAME OF FATHER JOHN T. REESE

18 BIRTHPLACE OF FATHER (City) (UNKNOWN)  
(State or country) N. J.

19 MAIDEN NAME OF MOTHER MARY E QUINN

20 BIRTHPLACE OF MOTHER (City) CORIK  
(State or country) IRELAND

21 Informant MARGARET REESE

(Address) 275 COURT RD WINTHROP, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

2672 - 1/17/64

(Date of Issuance of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



FEB 28 1964 AM

burial permit  
d of Health  
Agent.

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## OUT - OF - TOWN The Commonwealth of Massachusetts

21

Suffolk

(County)

PLACE OF DEATH

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this Death)

STANDARD  
CERTIFICATE OF DEATHRegistered No. ~~111111~~No. 250001. SHATTUCK HALL{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mr. Thekla. Schwartz  
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No.(a) Residence, No. 50 Cutler St.  
(Usual place of abode)St. Wintrop  
(City or town and State)Length of stay: In place of death.....years.....months. 13 days. In place of residence 6 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 1 17 64  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
1-3, 1964, to 1-17, 1964I last saw her alive on 1-17, 1964 death is said to  
have occurred on the date stated above, at 3:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hodgkin's DiseaseINTERVAL  
BETWEEN  
ONSET AND  
DEATHyrs.

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONSHodgkin's DiseaseWas autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify(Signature) W. S. A. Vasquez, M. D.(Address) 170 Morton St. JP Date 1/17 19646 Kaminber Cms. West Roxbury  
Place of Burial or Cremation (City or Town)DATE OF BURIAL January 19th 19647 NAME OF FUNERAL DIRECTOR Philip BlissADDRESS 470 HARVARD ST. BROOKLINEReceived and filed Jan 21 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWNMarried

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

Joseph Schwartz  
(Husband's name in full)

12

AGE 34 Years..... Months..... Days

If under 24 hours

Hours..... Minutes

13 Usual

Occupation

Housewife

(Kind of work done during most of working life)

14 Industry

or Business

at home

15 Social Security No.

not known

16 BIRTHPLACE (City)

(State or country)

Boston Mass

17 NAME OF

FATHER

David Friedman

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Boston

19 MAIDEN NAME

OF MOTHER

Ladie (Jersky)

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Boston21 Informant Henry Friedman

(Address)

31 Milk St. Boston MassI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:W. S. A. Vasquez 824146

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



h  
RECEIVED:  
*William Kane*  
City Registrar



FEB 28 1964 AM

FORM R-301

For burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
CAUSES  
DEATH

It enter  
than one  
for each  
b) and (c)

Does not mean  
of dying,  
heart failure,  
etc. It means  
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condition given

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6-934553

JURISDICTION WAIVED

PLACE OF DEATH

Suffolk  
(County)

Boston  
(City or Town)

No. New England Deaconess Hospital

2 FULL NAME Mrs. Norah Bateman (nee Ogden)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 89 Locust St. Winthrop, Mass.  
(Usual place of abode) 18 minutes  
(City or town and State)

Length of stay: In place of death years months days. In place of residence 1 year 6 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
January 19, 1964, to January 20, 1964

I last saw ~~de~~ alive on January 20, 1964, death is said to  
have occurred on the date stated above, at 12:08 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
PROBABLE MYOCARDIAL INFARCT

(a) CAUSING: ACUTE PULMONARY OEDEMA

Due To (b) ARTERIOSCLEROSIS

Due To (c)

OTHER SIGNIFICANT CONDITIONS  
DIABETES MELLITUS  
HYPERTENSION

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Josephine A. Stanton, M. D.

(Print or Type Name) JOSEPHINE A. STANTON

(Address) N.E.D.H. Date Jan. 20, 1964

6 Forest Dale Cemetery Malden Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 23, 1964

7 NAME OF FUNERAL DIRECTOR Colin H. Dennis

ADDRESS 144 Salem St Malden Mass

Received and filed JAN 22 1964 19

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 00680

{(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Widowed

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles B. Bateman  
(Husband's name in full)

12 AGE 63 Years 9 Months 10 Days If under 24 hours  
Hours Minutes

13 Usual Occupation House wife  
(Kind of work done during most of working life)

14 Industry or Business At Home

15 Social Security No. Unobtainable

16 BIRTHPLACE (City) Lanchishie  
(State or country) England

17 NAME OF FATHER Arthur Ogden

18 BIRTHPLACE OF FATHER (City) Unobtainable  
(State or country) England

19 MAIDEN NAME OF MOTHER Unobtainable

20 BIRTHPLACE OF MOTHER (City) Unobtainable  
(State or country) Unobtainable

21 Informant Frank B. Bateman

(Address) 12 Tufts Street Malden

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

(Registrar)

A TRUE COPY ATTEST:

*W. H. Kane.*  
X



FEB 28 1964 AM



for burial permit  
Board of Health  
to Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
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28 1964

PLACE OF DEATH

SUFFOLK  
(County)

BOSTON  
(City or Town)

No.



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

23  
(City or Town making this return)

Registered No. 00801

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Ada Altshuler

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

(a) Residence, No.  
(Usual place of abode)

65 Beach Road Winthrop, Mass.

St.  
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 23, 1964 Was a Patient  
(Month) (Day)

4 INTERVIEW CERTIFY Jan. 23, 1964  
I saw the body on Jan. 23, 1964, to Jan. 23, 1964

I saw the body on Jan. 23, 1964, to Jan. 23, 1964 death is said to  
have occurred on the date stated above, at 11.40am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac arrest

Min- Hrs.

(b) Myocardial Infarction

Hrs.

(c) Coronary Atherosclerosis

Mon.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) M. Winthrop O'Connell M.D.  
(Print or Type Name)

(Address) Jan. 23 64

6 MONTFLORE Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JANUARY 24 1964

7 NAME OF FUNERAL DIRECTOR Francis J. Glick

ADDRESS 645 BEACH ST. BOSTON MASS.

Received and filed JAN 28 1964 19.

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced  
HUSBAND of MAURICE (Give maiden name of wife in full)  
(or) WIFE of MAURICE ALTSHULER (Husband's name in full)

AGE 67 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation 1405 FINE (Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No.

16 BIRTHPLACE (City) LOWELL, MASS.  
(State or country)

17 NAME OF FATHER SAMUEL LAVINE

18 BIRTHPLACE OF FATHER (City) RUSSIA  
(State or country)

19 MAIDEN NAME OF MOTHER GRIBL

20 BIRTHPLACE OF MOTHER (City) RUSSIA  
(State or country)

21 Informant MAURICE ALTSHULER

(Address) 65 DEAN REAL WAY

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V.B.V.

A TRUE COPY ATTEST

*William J. Kane.*  
City Registrar



FEB 28 1964 AM

FORM R-301

For burial permit  
Board of Health  
's Agent.  
DUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
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b) and (c)

es not mean  
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28 1964

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932382

The Commonwealth of Massachusetts

SUFFOLK

(County)

BOSTON

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

24

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 00790

No. MASSACHUSETTS GENERAL HOSPITAL

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Patrick W. Harkins

(If deceased is a married, widowed or divorced woman, give also maiden name )

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 11 Summit Avenue  
(Usual place of abode)

St Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.9.....days. In place of residence.21.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 23 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
January 14, 1964, to January 23, 1964

I last saw him live on January 23, 1964, death is said to  
have occurred on the date stated above, at 4:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Acute tubular renal necrosis

(a) 8 days

(b) Intra-abdominal hemorrhage 9 days

(c) Abdominal aortic aneurysm Unknown

OTHER SIGNIFICANT CONDITIONS Burns 3°, buttocks 9 days

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify

(Signature) C. L. Clay, M.D.

Charles L. Clay, M.D.

(Print or Type Name)

(Address) Ave. 5, Dir. Mass. Gen'l. Hosp. Jan. 23, 1964

6 Holy Cross Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 27 1964

7 NAME OF FUNERAL DIRECTOR Ernest Hargrave

ADDRESS 147 Winthrop St Winthrop Mass

Received and filed JAN 28 1964

William J. Hane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed or divorced HUSBAND of Mary L Downey  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 80 Years 40 Months 22 Days If under 24 hours Hours Minutes

13 Usual Occupation: Store room helper Retired  
(Kind of work done during most working life)

14 Industry or Business: M. T. H.

15 Social Security No. 021-09-9417

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Patrick Harkins

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

19 MAIDEN NAME OF MOTHER Rose McLaughlin

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mrs Mary L Harkins  
(Address) 11 Summit Ave Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

30583-1/24/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



FEB 28 1964 AM



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit with  
Board of Health or its Agent.

CERTIFICATE OF FETAL DEATH  
(STILLBIRTH)

Registered No. **25**

PLACE OF DELIVERY

Suffolk  
(County)

Winthrop  
(City or Town)

No. Winthrop community Hospital

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 NAME OF FETUS Cardoza, Baby Girl #1  
(if given)

3 DATE OF DELIVERY **2 / 1 / 64**  
(Month) (Day) (Year)

4 SEX **#**  
Male. Female. Undetermined.

5 COLOR (if determined) **W**

6 THIS BIRTH (Check one)  
Single Twin Triplet

7 IF MULTIPLE BIRTH, BORN:  
1st 2nd 3rd

8 FULL NAME

FATHER  
Arthur M. Cardoza

14 MAIDEN NAME  
PRESENT NAME

MOTHER  
Catherine F. Aiken.  
Catherine F. Cardoza

9 RESIDENCE, NO. **442 Sumner St.** STREET  
CITY OR TOWN **E. Boston** STATE **Mass.**

15 RESIDENCE, NO. **442 Sumner St.** STREET  
CITY OR TOWN **East Boston,** STATE **Mass**

10 COLOR OR RACE **White** 11 AGE AT TIME OF THIS DELIVERY **35** (Years)

16 COLOR OR RACE **White** 17 AGE AT TIME OF THIS DELIVERY **33** (Years)

12 PLACE OF BIRTH **Boston, Mass.**  
(City or Town) (State or country)

18 PLACE OF BIRTH **East Boston, Mass.**  
(City or Town) (State or country)

13 OCCUPATION **Carpenter**

19 INFORMANT **Arthur M. Cardoza**

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus) **3**

(a) How many children are now living? **3**

(b) How many children were born alive but are now dead? **None**

(c) How many previous fetal deaths of ANY gestation age? **6**

21 LENGTH OF PREGNANCY **23**  
completed weeks

22 Weight Lb. OF FETUS Oz.  
(or Grams)

23 WHEN DID FETUS DIE?  
Before Labor During Labor or Delivery Unknown

24 AUTOPSY  
Yes No **A**

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **prematurity**

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS **none**

26 **Holy Cross** **Malden, Mass.**  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL **Feb, 3** 19 **64**

27 NAME OF FUNERAL DIRECTOR **Frederick J. Magrath.**  
ADDRESS **325 Chelsea St, East Poston.**

Received and filed **19**

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at **6:17 A.M.**, and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

**Joseph GREGG** M.D.  
**Joseph GREGG**  
(PRINT OR TYPE NAME)

Address **194 Washington Ave** Date **2-2-64**

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Siranni**  
(Signature of Agent of Board of Health or other)

**Health Officer** **February 3, '64**  
(Official Designation) (Date of Issue of Permit)

RECEIVED  
FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.



or burial permit  
rd of Health  
s Agent.

DUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
R CAUSES  
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for each  
b) and (c)

es not mean  
of dying,  
heart failure,  
tc. It means  
or compli-  
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The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

26

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

NO

2 FULL NAME Cardoza, Baby Girl #2  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 442 Sumner St.  
(Usual place of abode)

St. E. Boston, Mass.  
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 1, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
Feb. 1, 1964, to Feb. 1, 1964.  
I last saw her alive on Feb. 1, 1964 death is said to  
have occurred on the date stated above, at 8:02 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity -

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
1 hr 4 min

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph A. Aiken, M. D.

(Address) 194 Washington Ave., Boston, Mass.

Date Feb. 1, 1964

Holy Cross. Malden, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 3, 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath.

ADDRESS 325 Chelsea St, East Boston.

Received and filed Feb 3, 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE.....Years.....Months.....Days If under 24 hours  
I Hour 41 Minutes

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop, Mass.  
(State or country)

17 NAME OF FATHER Arthur M. Cardoza

18 BIRTHPLACE OF FATHER (City) Boston.  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine F. Aiken,

20 BIRTHPLACE OF MOTHER (City) East Boston.  
(State or country) Mass.

21 Informant (Address) Arthur M. Cardoza  
442 Sumner St. East Boston.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sircann (B)

(Signature of Agent of Board of Health or other)

Health Officer Feb 3, 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



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RULES OF PRACTICE

FEB 3 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit  
Board of Health  
's Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

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heart failure,  
etc. It means  
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the terminal  
condition given

V.C.

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 27

No. B-10 Viking Gardens (If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Fannie (Astrin) Rosenthal (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. B-10 Viking Gardens St. (Usual place of abode) (City or town and State)

Length of stay: In place of death, years, 1 months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 4, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19, to 19, I last saw h... alive on 19, death is said to have occurred on the date stated above, at 10:30 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural causes

(b) Presumably coronary occlusion and heart failure is

(c) Deceased had been under treatment for same

OTHER SIGNIFICANT CONDITIONS

Winthrop Board of Health  
Charles Liberman, M.D.

Was autopsy performed? What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signature) Charles Liberman, M. D.

(Print or Type Name) CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 2/5/64

6 Rabbi Isaac Elchonon Cem. Everett (City or Town)

DATE OF BURIAL Feb. 5, 1964

7 NAME OF FUNERAL DIRECTOR Murray Goldman

ADDRESS 174 Ferry St., Malden, Mass.

Received and filed FEB 6 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Hyman Rosenthal (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) Kiev (State or country) Russia

17 NAME OF FATHER Max Astrin

18 BIRTHPLACE OF FATHER (City) Unknown (State or country) Russia

19 MAIDEN NAME OF MOTHER Libby (Unknown)

20 BIRTHPLACE OF MOTHER (City) Unknown (State or country) Russia

21 Informant Edward Rosenthal

(Address) 49 Pearl Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:





SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit  
of Health  
Agent.

DUCTIONS  
FOR  
CERTIFICATE

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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

28

Registered No.

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

STANDARD  
CERTIFICATE OF DEATH

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

NO.

2 FULL NAME CATHERINE ANDERSON (MAYNES)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 94 BELLEVUE AVE., WINTHROP  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....17.....days. In place of residence.....25.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 5 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from  
APRIL 1963, to FEB 5 1964

I last saw him on FEB 5 1964, death is said to  
have occurred on the date stated above, at 5:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS

Due To CARCINOMATOSIS

(b) 2nd DAY

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS NINE

Was autopsy performed? No.  
What test confirmed diagnosis? BIOPSY AT OPERATION

5 Was disease or injury in any way related to occupation of deceased No.  
If so, specify

(Signature) Myron N. King, M.D.  
MYRON N. KING (M.D.)

(Address) 174 Winthrop St. Date 2/5-64

6 Winthrop Cemetery Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 8, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed FEB 6 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Charles Frederick Anderson  
(Husband's name in full)

12 AGE 61 Years 7 Months 10 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: bookbinder  
(Kind of work done during most working life)

14 Industry or Business commercial bookbinding

15 Social Security No. 011-20-0441

16 BIRTHPLACE (City) Boston  
(State or country) Massachusetts

17 NAME OF FATHER William Henry Maynes

18 BIRTHPLACE OF FATHER (City) Dorchester  
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mary Rose Regan

20 BIRTHPLACE OF MOTHER (City) Londonderry  
(State or country) Ireland

21 Informant (Address) Adrian C. Anderson

94 Bellevue Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
has been issued with me BEFORE the burial or transit permit was issued:

Joseph E. Seemann (Signature of Agent of Board of Health or other)

Health Officer February 6, 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



Suffolk

(County)


 KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

Winthrop

(City or Town)

 STANDARD  
 CERTIFICATE OF DEATH

Registered No.

29

 for burial permit  
 of Health  
 Agent.

 INSTRUCTIONS  
 FOR  
 CERTIFICATE

No. 10 Shore Drive,

 (If death occurred in a hospital or institution,  
 St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Abraham Davis

(If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a WW I  
 U. S. War Veteran,  
 if so specify WAR)

 (a) Residence. No. 10 Shore Drive  
 (Usual place of abode)

 St. Winthrop  
 (City or town and State)

Length of stay: In place of death 21 years.....months.....days. In place of residence 21 years.....months.....days.

 OR TYPE  
 OR CAUSES  
 DEATH

 not enter  
 than one  
 for each  
 (b) and (c)

 does not mean  
 of dying,  
 heart failure,  
 etc. It means  
 or compli-  
 which caused

 ins, if any,  
 have rise to  
 cause (a),  
 the under-  
 cause last.

 mions contrib-  
 each but not  
 the terminal  
 condition given

## MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH Feb 5, 1964  
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from  
 March 1960 to Feb. 5, 1964

 I last saw him alive on Feb. 4, 1964, death is said to  
 have occurred on the date stated above, at 2:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion,

(b) CORONARY ARTERY

(c) Heart DISEASE

 INTERVAL  
 BETWEEN  
 ONSET AND  
 DEATH

10 min.

4 1/2 yrs

 OTHER  
 SIGNIFICANT  
 CONDITIONS NONE

 Was autopsy performed? No  
 What test confirmed diagnosis? Clinica /

 5 Was disease or injury in any way related to occupation of deceased? Yes  
 If so, specify Required industrial Comp. in 1960

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. 215/19 64

 6 Pride of Boston Woburn  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL 2/6/64 19

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St Brookline, Mass

Received and filed FEB 6 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

 8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
 MARRIED Married  
 WIDOWED  
 DIVORCED  
 UNKNOWN

 11 If married, widowed, or divorced  
 HUSBAND of Bella Cohen  
 (Give maiden name of wife in full)

 (or) WIFE of  
 (Husband's name in full)

 12 AGE 67 Years Months 10 Days If under 24 hours  
 Hours Minutes

 13 Usual Occupation Truck Driver  
 (Kind of work done during most of working life)

14 Industry or Business Record - American

15 Social Security No. 011-01-9501

 16 BIRTHPLACE (City) Charlestown, Mass.  
 (State or country)

17 NAME OF FATHER Aaron Davis

 18 BIRTHPLACE OF FATHER (City) England  
 (State or country)

19 MAIDEN NAME OF MOTHER Fannie CBL

 20 BIRTHPLACE OF MOTHER (City) England  
 (State or country)

 21 Informant Selma Shahan  
 46 Homestead St. Waban  
 (Address)

 I HEREBY CERTIFY that a satisfactory standard certificate of death  
 was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan (S)

(Signature of Agent of Board of Health or other)

 Health Officer Feb. 5 1964  
 (Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....NAVAL.....RESERVE.....  
 DATE OF ENTERING MILITARY SERVICE.....8-14-1918.....BOSTON MASS  
 DATE OF DISCHARGE.....2-21-1919.....KEY PORT NEW JERSEY  
 RANK, RATING.....LANDSMAN.....FOR CARPENTER MATE A  
 ORGANIZATION AND OUTFIT.....NAVAL RESERVE  
 SERVICE NUMBER.....130-33-43

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB - 6 1964 PM

## The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.

30

STANDARD  
CERTIFICATE OF DEATH

Registered No. ....

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



No. BAY VIEW NURSING HOME, STURGIS

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

2 FULL NAME THOMAS H WARD

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

(a) Residence. No. 10 MARSHALL

(Usual place of abode)

St. WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death.....years. 3 months.....days. In place of residence 5 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 5, '64  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
1-19-64 to 2-5-64  
I last saw him live on 1-19-64, death is said to  
have occurred on the date stated above, at 6:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma of  
RectumINTERVAL  
BETWEEN  
ONSET AND  
DEATH

6 Mos.

Due To  
(b) .....Due To  
(c) .....OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....  
If so, specify.....(Signed) John F. Pepsi, M. D.  
(Address) Boston Mass. Date 2-6-1964ST PETERS BELLEVILLE N.J.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 8 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY  
ADDRESS WINTHROP

Received and filed FEB 7 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)  
MALE WHITE MARRIED  
WIDOWED WIDOWED  
or DIVORCED10a If married, widowed, or divorced  
HUSBAND of ANNA M. (HAU) WARD  
(Give maiden name of wife in full)(or) WIFE of.....  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 25 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation: CIVIL ENGINEER (RETIRED)  
(Kind of work done during most of working life)

14 Industry or Business: TOWN OF BELLEVILLE N.J.

15 Social Security No. 138-30-8200

16 BIRTHPLACE (City) JERSEY CITY  
(State or country) N.J.

17 NAME OF FATHER WILLIAM WARD.

18 BIRTHPLACE OF FATHER (City) IRELAND  
(State or country)

19 MAIDEN NAME OF MOTHER MARY (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) IRELAND  
(State or country)21 Informant MRS MARIE C. KENNEDY  
(Address) 10 MARSHALL ST WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:  
Ralph E. Seranin(Signature of Agent of Board of Health or other)  
Health Officer Feb 6 - 1964  
(Official Designation) (Date of Issue of Permit)

R-301A

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100M-11-95-916145



**EXTRACTS**  
FROM THE LAWS OF THE  
**COMMONWEALTH OF MASSACHUSETTS**  
GOVERNING THE  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION** .....

**DATE OF ENTERING MILITARY SERVICE** .....

**DATE OF DISCHARGE** .....

**RANK, RATING** .....

**ORGANIZATION AND OUTFIT** .....

**SERVICE NUMBER** .....

For burial permit  
of Health  
Agent.

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AL CERTIFICATE

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OUT - CIVIL TOWN

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

BOSTON

(City or Town making this return)

31

STANDARD  
CERTIFICATE OF DEATH

Registered No. 01289

No. Massachusetts General Hospital BAKER MEMORIAL

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Marie Wegener,

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

8 Surfside Avenue, Winthrop, Massachusetts

(a) Residence, No. St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....months.....1 days. In place of residence. 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 6, 1964  
(Month) (Day) (Year)

February 5, 1964 to February 6, 1964

I last saw her alive on February 6, 1964 death is said to

have occurred on the date stated above, at 12:20am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) JEJUNAL INFARCTION

Due To OMENTAL HERNIA

Due To

(c) OTHER SIGNIFICANT CONDITIONS GASTRIC ULCER

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy.

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify

(Signature) Charles L. Clay, M.D.

(Print or Type Name)

(Address) Mass. Gen. Hosp. Date 2-6-64 19.....

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 10 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed FEB 11 1964

William J. Kane

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 61 Years 3 Months 1 Days

If under 24 hours  
Hours Minutes

13 Usual Occupation Proprietor

(Kind of work done during most of working life)

14 Industry or Business Resturant

15 Social Security No. 019-28-6113

16 BIRTHPLACE (City) Germany  
(State or country)

17 NAME OF FATHER Jo haun Wegener

18 BIRTHPLACE OF FATHER (City) Germany  
(State or country)

19 MAIDEN NAME OF MOTHER Katherine

20 BIRTHPLACE OF MOTHER (City) Germany  
(State or country)

21 Informant Elizabeth Bradford

(Address) 8 Surfside Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

20447

(Official Designation)

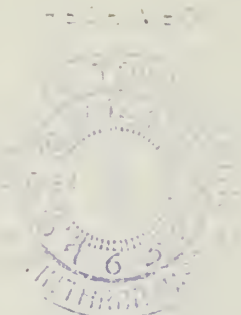
2-7-64

(Date of Issue of Permit)

V. 116

A TRUE COPY OF THE:

*Marion J. Lane.*  
✓ City Registrar



MAR - 9 1964 AM



FORM R-301

Suffolk  
(County)KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSWinthrop  
(City or Town making this return)Winthrop  
(City or Town)STANDARD  
CERTIFICATE OF DEATH

Registered No. 32

No. Bay View Nursing Home

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mathilda Tornrose ( Lilliefors )  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.(a) Residence. No. 64 Bates Avenue  
(Usual place of abode)St. Winthrop  
(City or town and State)

Length of stay: In place of death.....years. 10 months.....days. In place of residence 61 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 7 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
Oct. 1955 to Feb. 7 1964I last saw alive on Feb 7 1964 death is said to  
have occurred on the date stated above, at 2:40 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral hemorrhage

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 days

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Senility

yes

Was autopsy performed? NO

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify NO

(Signature) Harold B. Greenfield, M. D.

Harold B. Greenfield

(Address) 147 Snith St. Winthrop, Mass. Date 2-8 1964

6 Old Swedish Cemetery, Worcester  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 10 1964

7 NAME OF FUNERAL DIRECTOR Celest B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed FEB 10 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)  
MARRIED widowed

female white

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Idore Bror Tornrose  
(Husband's name in full)

12

AGE 88 Years 6 Months 8 Days

If under 24 hours

Hours Minutes

13

Usual Occupation housework

(Kind of work done during most of working life)

14

Industry or Business own home

15

Social Security No. 033-16-1304

16

BIRTHPLACE (City) Sweden  
(State or country)

17

NAME OF FATHER Ola Lilliefors

18

BIRTHPLACE OF FATHER (City) Sweden  
(State or country)

19

MAIDEN NAME OF MOTHER Anna Marie Pearson

20

BIRTHPLACE OF MOTHER (City) Sweden  
(State or country)

21

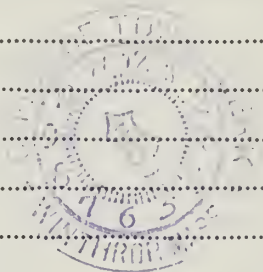
Informant Oliver W. Tornrose

(Address) 337 Washington St. Melrose

I HEREBY CERTIFY that a satisfactory standard certificate of death  
Mass filed with me BEFORE the burial or transit permit was issued:Ralph E. Siranum  
(Signature of Agent of Board of Health or other)Health Officer  
(Official Designation)February 10 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



RULES OF PRACTICE FEB 1 1964 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.





SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

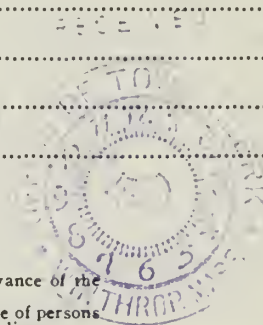
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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



STANDARD

CERTIFICATE OF DEATH

Registered No.

34

No. BAY VIEW NURSING HOME STURGEON'S

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MICHELA (SARNO) VITAGLIANO  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence No. 201 COTTAGE PARK RD  
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death... years. 4 months... days. In place of residence 40 years... months... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 12 1964  
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from Feb. 4 1964 to Feb. 12 1964  
I last saw him alive on Feb. 9 1964 death is said to have occurred on the date stated above, at 2:07 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease yrs  
(b) Atherosclerosis - gen yrs  
(c) Due To

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITION Diabetes Mellitus yrs  
Parkinson's Disease yrs

Was autopsy performed?  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased NO  
If so, specify

(Signature) Joseph P. Gregoire, M. D.  
(Print or Type Name) JOSEPH P. GREGOIRE  
(Address) 14 Housatonic Ave. Date 2-14 1963

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 14 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. WIRBY

ADDRESS WINTHROP, MASS.

Received and filed 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of JOHN G. VITAGLIANO (Husband's name in full)

12 AGE 78 Years... Months... Days If under 24 hours Hours Minutes

13 Usual Occupation: HOME MAKER (RETIRED)  
(Kind of work done during most of working life)

14 Industry or Business: HOME

15 Social Security No. NONE

16 BIRTHPLACE (City)... ITALY  
(State or country)

17 NAME OF FATHER ALFONSO SARNO

18 BIRTHPLACE OF FATHER (City)... ITALY  
(State or country)

19 MAIDEN NAME OF MOTHER GIUSEPPA D'AMORE

20 BIRTHPLACE OF MOTHER (City)... ITALY  
(State or country)

21 Informant PHILIP VITAGLIANO

(Address) 201 COTTAGE PARK RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph P. Gregoire (Signature of Agent of Board of Health or other)  
Health Officer Feb 13, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....



FEB 13 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



For burial permit  
of Health  
Agent.

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use last.

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to the terminal  
condition given

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

## STANDARD CERTIFICATE OF DEATH

Registered No. 35

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

### PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

2 FULL NAME Rose Klein Jacobson  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence 40 Trident Avenue, Winthrop  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death... years... months... 2 days. In place of residence... 10 years... months... days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Aug 1962, to Feb 15, 1964  
I last saw her alive on Feb 14, 1964, death is said to  
have occurred on the date stated above, at 7:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, Right Base lwr.

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Lieberman, M. D.

(Address) WINTHROP, MASS. Date 2/15/64

6 KLEINER EVERETT  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB 16 1964

7 NAME OF FUNERAL DIRECTOR TORI - funeral Service

ADDRESS Washington Chelsea

Received and filed Feb 18, 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEM 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Joseph JACOBSON  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

12 AGE 80 Years... Months... Days If under 24 hours  
Hours... Minutes

13 Usual Occupation: Proprietor Pot  
(Kind of work done during most working life)

14 Industry or Business: Grocery Store

15 Social Security No. No.

16 BIRTHPLACE (City)... HUNGARY  
(State or country)

17 NAME OF FATHER ZVI KLEIN

18 BIRTHPLACE OF FATHER (City)... Hungary  
(State or country)

19 MAIDEN NAME OF MOTHER ORL

20 BIRTHPLACE OF MOTHER (City)... Hungary  
(State or country)

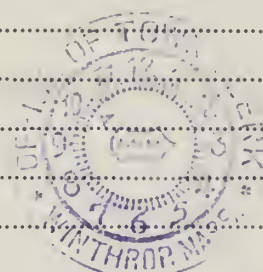
21 Informant MAURICE KLEIN  
(Address) Pleasant St Brookline

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Sweeney (Signature of Agent of Board of Health or other)

Health Officer Feb 15 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



FEB 18 1964 A.M. PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

## The Commonwealth of Massachusetts

JOSEPH D WARD

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No.

Winthrop Community Hospital

STANDARD  
CERTIFICATE OF DEATH

Registered No. 36

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran,  
{ if so specify WAR) no

2 FULL NAME Bruce, Baby Boy

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 171 Faywood Avenue, East Boston, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 17 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Feb 17, 1964, to Feb 17, 1964I last saw him alive on Feb 17, 1964, death is said to  
have occurred on the date stated above, at 7:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Premature Separation of  
placenta

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John D. Latoroella, M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 305 Chelsea St. Date Feb 17, 1964

6 Holy Cross Cemetery, Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 20 1964

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston

Received and filed 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED single

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE. Years. Months. Days If under 24 hours  
4 Hours. 33 Minutes13 Usual Occupation: None -  
(Kind of work done during most of working life)

14 Industry or Business: None -

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop, Mass.  
(State or country)

17 NAME OF FATHER

Robert Bruce

18 BIRTHPLACE OF FATHER (City)

Boston

(State or country)

Mass.

19 MAIDEN NAME OF MOTHER

Patricia LaBella

20 BIRTHPLACE OF MOTHER (City)  
(State or country)

Boston

Mass.

21 Informant Domenico LaBella (Grandfather)  
(Address) 102 Falcon St., East Boston, Mass.I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sullivan (3)  
(Signature of Agent of Board of Health or other)Health officer Feb 20, 1964  
(Official Designation) (Date of Issue of Permit)

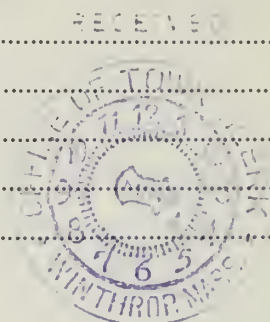
R-301A

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o hint or type  
no signature.

1-69-925686



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **37**

PLACE OF DEATH

**SUFFOLK**

(County)

**WINTHROP**

(City or Town)

No. **27 BELCHER**

{ (If death occurred in a hospital or institution,  
St. { (If its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **JOSEPH E. FORRISTALL**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a  
U. S. War Veteran, **NO**  
if so specify WAR)

(a) Residence, No. **14 BELCHER**  
(Usual place of abode)

St. **WINTHROP**  
(City or town and State)

Length of stay: In place of death, years, months, days. In place of residence **50** years, months, days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **February 18, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased, from **JUNE 5, 1960**, to **FEB 18, 1964**

I last saw him alive on **FEB 18, 1964** death is said to have occurred on the date stated above, at **1045 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **ACUTE CORONARY OCCLUSION**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**5 MIN**

Due To **ARTERIO-SCLEROTIC**  
(b) **HEART DIS**

**3 1/2 YRS.**

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

**NONE**

Was autopsy performed? **NO**

What test confirmed diagnosis? **CLINICAL**

5 Was disease or injury in any way related to occupation of deceased **NO**  
If so, specify

(Signature) **Myron N King** M. D.  
**MYRON N KING M.D.**  
(Print or Type Name)

(Address) **210 Pleasant St Wintthrop** Date **FEB 21, 1964**

6 **WINTHROP** **WINTHROP**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **FEB 22, 1964**

7 NAME OF FUNERAL DIRECTOR **MAURICE W. KIRBY**

ADDRESS **WINTHROP**

Received and filed **FEB 21 1964** 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **MARRIED**

11 If married, widowed, or divorced  
HUSBAND of **FRANCES M. STINSON**  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **56** years, months, days If under 24 hours  
Hours, Minutes

13 Usual Occupation **TOLL COLLECTOR**  
(Kind of work done during most of working life)

14 Industry or Business **BOSTON PORT AUTHORITY**

15 Social Security No.

16 BIRTHPLACE (City) **EAST BOSTON**  
(State or country) **MASS**

17 NAME OF FATHER **JOHN FORRISTALL**

18 BIRTHPLACE OF FATHER (City) **EAST BOSTON**  
(State or country) **MASS**

19 MAIDEN NAME OF MOTHER **MARY E KIRLEY**

20 BIRTHPLACE OF MOTHER (City) **IRELAND**  
(State or country)

21 Informant **MRS FRANCES FORRISTALL**  
(Address) **14 BELCHER ST WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Sweeney (2)**  
(Signature of Agent of Board of Health or other)

**Health officer** **FEB 21, 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

for burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
CAUSES  
DEATH

ot enter  
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ul for each  
(a) (b) and (c)

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as heart failure,  
etc. It means  
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g cause last.

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to death but not  
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dition given

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



FEB 21 1964 PM



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **38**

Suffolk

(County)

Winthrop

(City or Town)

Bay View Nursing Home

No.

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Myrtle (Murphy) Schleber**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO**

**120 Crest Ave.**

(a) Residence, No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death, **12** years, **50** months, **12** days. In place of residence, **50** years, **50** months, **12** days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **February 19 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from **Jan 1958** to **February 15 1964**  
I last saw her alive on **Feb 15 1964**, death is said to have occurred on the date stated above, at **5:00 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **myocardial infarction**

Due To

(b) **Coronary arteriosclerosis**

Due To

(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**15 min.**

OTHER SIGNIFICANT CONDITIONS **Congestive heart failure min.**

Was autopsy performed? **NO**

What test confirmed diagnosis? **Ecg. X-Rays**

5 Was disease or injury in any way related to occupation of deceased? **NO**  
If so, specify

(Signature) **H. B. Keenfield**, M. D.

**447 Shiley St. Winthrop**  
(Print or Type Name)

(Address) **Winthrop** Date **2-20 1964**

**Winthrop** **Winthrop**  
6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Feb. 21 1964**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop, Mass**

Received and filed **FEB 21 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED** **Divorced**  
**UNKNOWN**

11 If married, widowed, or divorced  
HUSBAND of **Louis E Schleber** (Give maiden name of wife in full)  
(or) WIFE of **Louis E Schleber** (Husband's name in full)

12 AGE **86** Years **1** Months **17** Days If under 24 hours  
Hours Minutes

13 Usual Occupation: **Saleswoman**  
(Kind of work done during most of working life)

14 Industry or Business: **Dress shop**

15 Social Security No. **011-05-7782**

16 BIRTHPLACE (City) **Hamilton**  
(State or country) **Ohio**

17 NAME OF FATHER **William Murphy**

18 BIRTHPLACE OF FATHER (City) **Unable to obtain**  
(State or country)

19 MAIDEN NAME OF MOTHER **Eliza**

20 BIRTHPLACE OF MOTHER (City) **Unable to obtain**  
(State or country)

21 Informant **Records Old Age Assistance**  
(Address) **Winthrop, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Sieranni (o.)**  
(Signature of Agent of Board of Health or other)  
**Health Officer** **Feb 21 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

ORM R-301

et or burial permit  
Bird of Health  
s Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

N OR TYPE  
SEOR CAUSES  
OF DEATH

do not enter  
more than one  
cause for each  
a, (b) and (c)

is does not mean  
me of dying,  
at heart failure,  
mid etc. It means  
issue, or compli-  
ss which caused

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ove cause (a),  
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Conitions contrib-  
te death but not  
d the terminal  
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6-933404

SPACE FOR ADDITIONAL INFORMATION .....

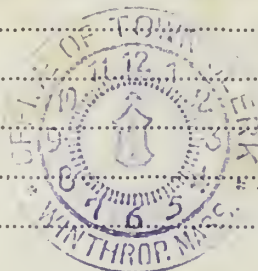
DATE OF ENTERING MILITARY SERVICE.....RECEIVED.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



RULES OF PRACTICE  
FEB 21 1984 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

FOR TYPE  
CAUSES  
DEATH

Not enter  
than one  
for each  
(b) and (c)

Not mean  
of dying,  
ear failure,  
etc. It means  
or compli-  
which caused

Not, if any,  
rise to  
cause (a),  
he under-  
cause last.

Contrib-  
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the terminal  
condition given

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk  
(County)

Winthrop  
(City or Town)



STANDARD  
CERTIFICATE OF DEATH

Registered No. 39

No. 102 Bowdoin Street, Winthrop (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Ralph G. Ferrante  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW 2

(a) Residence, No. 102 Bowdoin Street  
(Usual place of abode)

Length of stay: In place of death 14 years, months, days. In place of residence 13 years, months, days. (City or town and State)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 20, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19, death is said to have occurred on the date stated above, at 1:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due to Natural causes, due to complications from existing

(c) Due to Hypertension, possibly acute coronary occlusion.

OTHER SIGNIFICANT CONDITIONS Winthrop Board of Health Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman, M.D.

(Address) WINTHROP, MASS Date 2/20/1964

6 Holy Cross Cemetery, Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 24th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of Gloria A. Tammaro (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 36 Years 3 Months 15 Days If under 24 hours Hours Minutes

13 Usual Occupation Clerk (Kind of work done during most of working life)

14 Industry or Business: Veterans Administration

15 Social Security No. 011-20-5343

16 BIRTHPLACE (City) East Boston (State or country) Mass.

17 NAME OF FATHER Ralph Ferrante

18 BIRTHPLACE OF FATHER (City) Providence (State or country) Rhode Island

19 MAIDEN NAME OF MOTHER Angelina Diorio

20 BIRTHPLACE OF MOTHER (City) Chelsea (State or country) Mass.

21 Informant Mrs. Gloria A. Ferrante-wife

(Address) 102 Bowdoin St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Liberman (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) February 20, 1964 (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE..... Jan. 8, 1945

DATE OF DISCHARGE..... Nov. 8, 1945

RANK, RATING ..... Pvt.

ORGANIZATION AND OUTFIT..... U.S.A.

SERVICE NUMBER..... 31 439 298



**RULES OF PRACTICE**

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For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
OR  
CERTIFICATE

FOR TYPE  
CAUSES  
DEATH

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or each  
) and (c)

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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WINTHROP  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 40

1 PLACE OF DEATH  
Suffolk (County)  
Winthrop (City or Town)  
No. 24 Atlantic St.,  
2 FULL NAME Mary S. Mayer (Sears)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Residence. No. 24 Atlantic St.,  
(Usual place of abode)  
Length of stay: In place of death 40 years.....months.....days. In place of residence.....years.....months.....days.

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, NO  
(if so specify WAR)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 21 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
March 1, 1958, to February 21, 1964  
I last saw him alive on February 20, 1964, death is said to  
have occurred on the date stated above, at 10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease 5 yrs.  
(b) Generalized arteriosclerosis 7 yrs.  
(c)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS Nephrosclerosis 5 yrs.

Was autopsy performed? no  
What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased no  
If so, specify:

(Signature) M. Traunstein, Jr., M.D.  
(Print or Type Name)  
(Address) 73 Bartlett Rd. Feb. 21, 64  
Winthrop, Mass. 02152  
6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Widowed DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Frank Mayer (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

12 AGE 81 Years.....Months.....Days If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Brookline (State or country) Mass

17 NAME OF FATHER Matthew Sears

18 BIRTHPLACE OF FATHER (City) Azores (State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country)

21 Informant Harold Mayer (Address) 26 Atlantic St., Winthrop

DATE OF BURIAL February 24 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley  
Winthrop Mass  
ADDRESS  
Received and filed FEB 24 1964  
John A. Clarke (Registrar)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
Joseph E. Scramm (Signature of Agent of Board of Health or other)  
Health Officer February 24 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

RECEIVED  
FEB 24 1964 AM  
TOWNSHIP  
8  
THROP  
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care, or who die at home from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

FOR TYPE  
CAUSES  
DEATH

Not enter  
more than one  
cause for each  
(a), (b) and (c)

is not mean  
cause of dying,  
heart failure,  
etc. It means  
cause, or compli-  
cations which caused

itions, if any,  
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to death but not  
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PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Anne Wright (Borden)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 180 Nahant Avenue  
(Usual place of abode)

St. Winthrop, Mass.  
(If nonresident, give city or town and State)

Length of stay: In place of death.....years. 1 months. 14 days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH FEB 23 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
DEC 1962 to FEB 23 1964

I last saw him alive on FEB 23 1964 death is said to  
have occurred on the date stated above, at 140 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ALEUKEMIC MYELOGENOUS  
LEUKEMIA

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes - R. Borden, M.D.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Myron N. King, M.D.

MYRON N. KING, M.D.  
(Print or Type Name)

(Address) 222 PLEASANT ST. Winthrop, Mass.  
Date 2/23/64

6 Cedar Grove Dorchester, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 26 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed February 25 1964

(Registrar)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

Registered No. 44

{(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
Harry E Wright  
(or) WIFE of (Husband's name in full)

12 AGE 78 1 28  
Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. 023-16-9776

16 BIRTHPLACE (City, State or country) Advocate  
Nova Scotia

17 NAME OF FATHER Clifford K Borden

18 BIRTHPLACE OF FATHER (City, State or country) Pugwash  
Nova Scotia

19 MAIDEN NAME OF MOTHER Bessie A Spicer

20 BIRTHPLACE OF MOTHER (City, State or country) Spensers Island  
Nova Scotia

21 Informant Harry E Wright  
(Address)

180 Nahant Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Keith E. Brennan (Signature of Agent of Board of Health or other)

February 25 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FEB 25 1964 AM

For burial permit  
of Health  
Agent.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

2 FULL NAME

Frank O. Arnoldson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

45 Perkins St

(a) Residence. No.

(Usual place of abode)

St.

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. years 1 months 20 days. In place of residence. 17 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 26, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from 1/16, 1964, to 2/26, 1964

I last saw him live on 2/26, 1964, death is said to have occurred on the date stated above, at 7:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Old + Recent Pulmonary Emboli

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Abdominal Fistula

INTERVAL BETWEEN ONSET AND DEATH

4 days

5 wks

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Myron H. King, M. D.

MYRON H. KING M.D.  
(Print or Type Name)

(Address) 222 PLEASANT ST, WINTHROP MASS Date 2/26, 1964

6 Mt. Auburn Cemetery Cambridge  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 28, 1964

7 NAME OF FUNERAL DIRECTOR Short & Williston Inc.

ADDRESS 52 Trapelo Rd, Belmont

Received and filed FEB 28 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Hazel May Barnett (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years 12 Months 9 Days If under 24 hours Hours Minutes

13 Usual Occupation: Painting Contractor (retired) (Kind of work done during most working life)

14 Industry or Business Arnoldson & Son, Belmont

15 Social Security No. 021209-7656

16 BIRTHPLACE (City) Waltham, Mass (State or country)

17 NAME OF FATHER Frank O. Arnoldson

18 BIRTHPLACE OF FATHER (City) Sweden (State or country)

19 MAIDEN NAME OF MOTHER Jennie Rostrom

20 BIRTHPLACE OF MOTHER (City) Sweden (State or country)

21 Informant Mrs Hazel Arnoldson - wife (Address) 45 Perkins St, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Suranma (Signature of Agent of Board of Health or other)

Health Officer Feb. 26, 1964 (Official Designation) (Date of Issue of Permit)

Removed IN BK. A.T. Elce

V.R.V.

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

FEB 28 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 232 Main Street

Esther Ann (Robinson) Bradshaw

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

232 Main Street

(a) Residence. No. (Usual place of abode)

St. (City or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 26 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Jan. 1963, to Feb. 26 - 1964  
I last saw her alive on Feb. 25, 1964 death is said to have occurred on the date stated above, at 6 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic Cd -  
Due To Primary Bowel }  
(b) }  
Due To Cd - }  
(c) }

INTERVAL BETWEEN ONSET AND DEATH

1 yr. 3 yrs.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) John D. Latorella, M. D.  
(Print or Type Name)  
(Address) 305 Chelsea St. Date Feb 27 1964

6 Woodlawn Crematory Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 28 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed FEB 28 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 43

(If death occurred in a hospital or institution, St. (give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of William Bradshaw (Husband's name in full)

12 AGE 75 Years 1 Months 21 Days If under 24 hours Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business Own home

15 Social Security No. 010-05-7263

16 BIRTHPLACE (City) (State or country) England

17 NAME OF FATHER John J Robinson

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Emily Pickersgill

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant William Bradshaw

(Address) 232 Main St. Winthrop

I HEREBY CERTIFY that a satisfactory certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Suranni (B)

(Signature of Agent of Board of Health or other) Health Officer February 28 1964

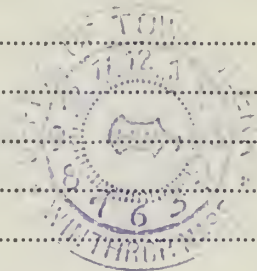
(Official Designation) (Date of Issue of Permit) 11/1/64

A TRUE COPY ATTEST.

2-28-64 Removed MBK. A.T. Elze

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

RECEIVED



#### RULES OF PRACTICE

FEB 28 1964 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



SUFFOLK

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

Baby Girl Brangiforte

2 NAME OF FETUS  
(if given)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with  
Board of Health or its Agent.

Registered No. 44

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)3 DATE OF DELIVERY FEB. 26-1964  
(Month) (Day) (Year)4 SEX  
Male Female ☒ Undetermined

5 COLOR (if determined) W

6 THIS BIRTH (Check one)  
Single ☒ Twin Triplet7 IF MULTIPLE BIRTH, BORN:  
1st 2nd 3rd8 FATHER  
FULL NAME Domenic Brangiforte9 RESIDENCE, NO. 10 McClure St. STREET  
CITY OR TOWN Revere STATE Mass.

10 COLOR OR RACE W 11 AGE AT TIME OF THIS DELIVERY 24 (Years)

12 PLACE OF BIRTH Boston Mass.  
(City or Town) (State or country)

13 OCCUPATION Auto Mechanic

14 MOTHER  
MAIDEN NAME Dolores Pepe  
PRESENT NAME Dolores Brangiforte15 RESIDENCE, NO. 10 McClure STREET  
CITY OR TOWN Revere STATE Mass.

16 COLOR OR RACE W 17 AGE AT TIME OF THIS DELIVERY 21 (Years)

18 PLACE OF BIRTH Boston Mass.  
(City or Town) (State or country)

19 INFORMANT Domenic Brangiforte

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus)

(a) How many children are now living? one

(b) How many children were born alive but are now dead? none

(c) How many previous fetal deaths of ANY gestation age? none

21 LENGTH OF PREGNANCY completed weeks 43

22 Weight Lb. 7 Oz. 10  
(or Grams)23 WHEN DID FETUS DIE?  
Before Labor During Labor or Delivery Unknown24 AUTOPSY Yes ☒ No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Patent Foramen Ovale

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Meconium Aspiration

26 Holy Cross Cemetery Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 29 19 64

27 NAME OF FUNERAL DIRECTOR Vincent Rapino  
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed 19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 2a m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Charles Meloni M.D.

CHARLES MELONI  
(PRINT OR TYPE NAME)

Address 45 Baywater St. E Boston Date Feb. 27 1964

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranni (B)  
(Signature of Agent of Board of Health or other)Health Officer Feb 28, 1964  
(Official Designation) (Date of Issue of Permit)

## FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

No.

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

45

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

NO

2 FULL NAME THOMAS P. MCLAUGHLIN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

49 Bartlett Rd., Winthrop Mass.

(a) Residence, No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 10 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 26 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
APRIL 59, 1959, to FEB 26, 1964  
I last saw him on Feb 26, 1964, death is said to  
have occurred on the date stated above, at 2:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY INFARCT. 20 DAYS

Due To (b) ARTERIO-SCLEROTIC HEART DISEASE 1 YR.

Due To (c) HYPERTENSIVE HEART DYS

OTHER SIGNIFICANT CONDITIONS PULMONARY INFILTRATION 1 wk.  
LEFT BASE

Was autopsy performed? NO

What test confirmed diagnosis? CLINICAL, EKG, X-RAY

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) MYRON N. KING M.D.  
(Print or Type Name)

(Address) 212 PLEASANT ST. Date 2/26/64

St. Joseph West Roxbury  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 29, 1964

7 NAME OF FUNERAL DIRECTOR Charles P. Chapman

ADDRESS 5 Canton Ave. Milton

Received and filed FEB 27 1964 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of LOUISE A. Daque  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE 69 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Retail Pres.  
(Kind of work done during most working life)

14 Industry or Business: VERA A. Rubber Co.

15 Social Security No. 023-03-6887

16 BIRTHPLACE (City) Burlington VT.  
(State or country)

17 NAME OF FATHER Thomas M. Laughlin

18 BIRTHPLACE OF FATHER (City) Burlington VT.  
(State or country)

19 MAIDEN NAME OF MOTHER Anne Kennedy

20 BIRTHPLACE OF MOTHER (City) Burlington VT.  
(State or country)

21 Informant Mrs. LOUISE A. McLaughlin  
(Address) 49 Bartlett Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Soranno (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) Feb 27-1964 (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

FEB 27 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Danvers 46

(City or Town making this return)

Essex

(County)

Danvers

(City or Town)

Danvers State Hos. Hathorne

No. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Marie Kuhns

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Permanent Residence. No. (Usual place of abode)

130 Grove St.

Winthrop., Mass.

(City or town and State)

Length of stay: In place of death years months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 1, 1964

(Month) (Day) (Year)

Dec. 31 BY CEASED IF Feb. 1 that attended deceased from

I last saw him alive on Feb. 1, 64, death is said to

have occurred on the date stated above, at m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Bronchopneumonia

(a)

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Clin. & Labo.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Willard M. Hausman Willard M. Hausman, M. D.

Hathorne, Mass. 2/1/64

(Address) Date 19

Cedar Grove Cemetery, Dorchester

6 Place of Burial or Cremation Feb. 3, 1964 (City or Town)

DATE OF BURIAL 19

7 NAME OF FUNERAL DIRECTOR Cole & Gleason

Dorchester, Mass.

ADDRESS Feb. 6, 1964

Received and filed 19

APR 8 1964

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

Frank A. Kuhns (Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

82

11

9

AGE Years Months Days If under 24 hours

13 Usual

Occupation:

unable to work

(Kind of work done during most of working life)

14 Industry or Business:

018-22-1912

15 Social Security No.

Boston

16 BIRTHPLACE (City)

Mass.

(State or country)

17 NAME OF FATHER

William H. Borarik

18 BIRTHPLACE OF FATHER (City)

unknown

(State or country)

Canada

19 MAIDEN NAME OF MOTHER

Margaret Young

20 BIRTHPLACE OF MOTHER (City)

unknown

(State or country)

England

21 Informant

Georgie T. Brinigion

Danvers, Mass.

(Address)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Feb. 6, 1964

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

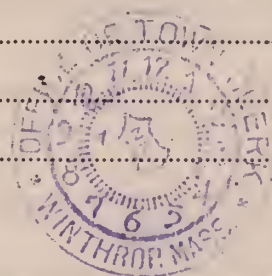
DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....



APR - 8 1964 AM



Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town which the deceased resided at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

PLACE OF DEATH

Suffolk

(County)

Revere

(City or Town)

No. Grover Manor Hospital

The Commonwealth of Massachusetts



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Revere 47  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. ....

St. { (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME Mabel Evans (Lawson)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a  
U. S. War Veteran,  
if so specify WAR, .....

(a) Residence. No. 46 Washington Avenue  
(Usual place of abode)

St. Winthrop  
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 4 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Jan. 30, 1964, Feb. 12, 1964  
I last saw her alive on Feb. 12, 1964  
have occurred on the date stated above, at 8:45P.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
48hrs.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia  
Due To Cerebral vascular  
(b) accident lmo.

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Clinical signs

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify No

(Signed) James F. Burns, M. D.

(Address) 405 Washington Ave. 2/13 64  
Revere

6 Riverside Saugus  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 17, 1964

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds

ADDRESS Winthrop, Mass.

Received and filed MAR 13 1964

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED Widow  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Thomas Evans  
(or) WIFE of Thomas Evans  
(Give maiden name of wife in full)  
(Husband's name in full)

12 AGE 81 Years.....Months.....Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: None  
(Kind of work done during most working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) Merrimac  
(State or country) Mass.

17 NAME OF FATHER Andrew D. Lawson

18 BIRTHPLACE OF FATHER (City) Prince Edward Island  
(State or country)

19 MAIDEN NAME OF MOTHER Mary E. Small

20 BIRTHPLACE OF MOTHER (City) Massachusetts  
(State or country)

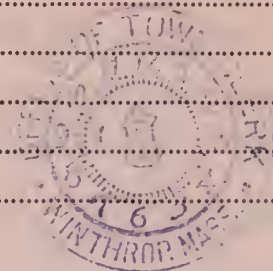
21 Informant Fred Lawson  
(Address) 10 West St., Stoneham

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED February 14, 1964

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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MAR 13 1964 AM

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PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

No. Massachusetts General Hospital



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

48

(City or Town making this return)

# STANDARD CERTIFICATE OF DEATH

Registered No. 01551

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Gertrude Hoffman  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WARI) No

(a) Residence, No. 41 Cutler Street St. Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years, months, 3 days. In place of residence, 25 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 13 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That deceased died on February 12 1964, to February 13 1964

last saw him alive on February 13 1964, death is said to have occurred on the date stated above, at 8:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lobar pneumonia

(b) Due To Left temporal lobe brain tumor

(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

days

5 mos

OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? noWhat test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? ....  
If so, specify Chloroform

(Signature) Charles L. Clay, M.D., M. D.

Charles L. Clay, M.D.  
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 13 1964

6 Hebrew Volin West Roxbury  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 14 19647 NAME OF FUNERAL DIRECTOR Henry LevineADDRESS 470 Harvard St., BrooklineReceived and filed FEB 18 1964 19

William J. Hane  
A TRUE COPY ATTEST

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Harry Hoffman  
(Give maiden name of wife in full)

(or) WIFE of Harry Hoffman  
(Husband's name in full)

12 AGE 62 Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation: Realtor  
(Kind of work done during most of working life)

14 Industry or Business: Real estate

15 Social Security No. 020-32-4840

16 BIRTHPLACE (City) Russia  
(State or country)

17 NAME OF FATHER Jacob Wayte  
address 222 222

18 BIRTHPLACE OF FATHER (City) Russia  
(State or country)

19 MAIDEN NAME OF MOTHER Dora Bendon  
address 222 222

20 BIRTHPLACE OF MOTHER (City) Russia  
(State or country)

21 Informant Sumner Hoffman  
3 Cresthaven Dr.  
(Address) Burlington, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Donald D. Souza  
(Signature of Agent of Board of Health or other)

30601  
(Official Designation)

2-14-64  
(Date of Issue of Permit)

V. 10



A TRUE COPY ATTEST:

*William J. Kane.*  
City Register

RECEIVED



MAR 27 1964 AM

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No. 01689

No. U. S. Public Health Service Hospital (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph J Martin (First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence, No. 363 Shirley St. Winthrop, Mass.  
(Usual place of abode) (If non-resident, give city or town and State)

Length of stay: In place of death 0 years 2 months 15 days. In place of residence 10 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 17, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
December 4, 1963, to February 17, 1964  
I last saw him alive on February 17, 1964, death is said to  
have occurred on the date stated above, at 4:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma of the stomach

~~XXXX~~ with generalized  
~~XXXX~~ Carcinomatosis

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 mos

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes  
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Robert A. Jordan, M.D.  
(Print or Type Name)

(Address) USPHSH, Boston, Mass. date Feb. 17, 1964

6 Pine Grove Lynn Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb 20, 1964

7 NAME OF FUNERAL DIRECTOR H. C. Goodrich

ADDRESS 128 Washington St Lynn Mass

Received and filed FEB 24 1964 19

A TRUE COPY ATTEST: L. J. Leonard, Registrar

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced.  
HUSBAND of John Marie Himes (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH Dec 14 1892

13 AGE 71 Years 2 Months 3 Days If under 24 hours Hours Minutes

14 Usual Occupation: Cook & Fisherman (Kind of work done during most of working life)

15 Industry or Business: Fishing Tackle

16 Social Security No. 0310-07-0175

17 BIRTHPLACE (City) Godfrey (State or country) Newfoundland

18 NAME OF FATHER Steven Martin

19 BIRTHPLACE OF FATHER (City) Godfrey (State or country) Newfoundland

20 MAIDEN NAME OF MOTHER Helen Ryan

21 BIRTHPLACE OF MOTHER (City) Grand River (State or country) Newfoundland

22 Informant (Address) Edith Martin 112 Broad St Lynn Mass

I HEREBY CERTIFY, that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

*William J. Kane.*

Col. Register

Not a true copy of the original document.



MAR 27 1964 AM



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OUT - OF - TOWN

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

50

(City or Town making this return)

Suffolk  
(County)

Boston  
(City or Town)



STANDARD  
CERTIFICATE OF DEATH

Registered No. 01992

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Alphonse RICUPERO (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, WWII if so specify WAR)

(a) Permanent Residence, No. 108 Shirley St. Winthrop, Mass. (Usual place of abode) (City or town and State)

Length of stay: In place of death, years, months, 16 days. In place of residence, years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 26 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That VA attended deceased from February 10, 1964 to February 26, 1964.

death is said to have occurred on the date stated above, at 8 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

Due To Congestive heart failure 5 weeks

Due To Arteriosclerotic heart disease years

## OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Clinical & lab findings

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Warren Kantrowitz, M. D.  
(Print or Type Name)  
(Address) V.A.H., Boston, Mass. Date 2/27/64

6 Holy Cross Cemetery, Malden, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 29 1964

7 NAME OF FUNERAL DIRECTOR Rapino Memorial Home

ADDRESS 9 Chelsea St, E. Boston, Mass

Received and filed MAR 2 1964

William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married WIDOWED Divorced UNKNOWN

11 If married, widowed or divorced HUSBAND of Elizabeth Cardinale (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 47 Years 6 Months 25 Days If under 24 hours Hours Minutes

13 Usual Occupation Mechanic's Helper (Retired) (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. 030-09-6319

16 BIRTHPLACE (City) East Boston (State or country) Mass.

17 NAME OF FATHER Dennis Ricupero

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Leona Ida Rainone

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant V.A. Hospital Records, 150 S. Huntington Ave., Boston 30, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

20808 2-20-64 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Koss.*



MAR 27 1964 AM

## The Commonwealth of Massachusetts

51

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

Danvers  
 (City or Town making this return)

COPY OF  
 CERTIFICATE OF DEATH

Registered No. ....

PLACE OF DEATH

Essex  
 (County)

Danvers  
 (City or Town)

No. Danvers State Hqs. Hathorne

(If death occurred in a hospital or institution,  
 St. give its NAME instead of street and number)

2 FULL NAME John Jorgenson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
 U. S. War Veteran,  
 if so specify WAR) no

(a) Permanent Residence. No. 23 South Avenue, St. Winthrop, Mass.  
 (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 29, 1964  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
 Jan. 27, 1964, to Feb. 29, 1964

I last saw him alive on Feb. 29, 1964, death is said to  
 have occurred on the date stated above, at 9:55 pm

INTERVAL  
 BETWEEN  
 ONSET AND  
 DEATH  
 Wks

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bilateral Lobar pneumonia

Due To

(b)

Due To

(c)

OTHER arteriosclerotic ht dis. yrs  
 SIGNIFICANT gen arteriosclerosis yrs  
 CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clin. &amp; Lab.

5 Was disease or injury in any way related to occupation of deceased? ....  
 If so, specify

(Signature) Willard M. Hausman, M. D.  
 Willard M. Hausman

(Address) Hathorne, Mass. Date 2/27/1964

6 Winthrop Cemetery, Winthrop, Mass.  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 3, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS Winthrop, Mass.

Received and filed March 4, 1964

APR 8 1964

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

male

white

MARRIED  
 WIDOWED  
 DIVORCED married  
 UNKNOWN

11 If married, widowed, or divorced  
 HUSBAND of Jennie Peterson

(Give maiden name of wife in full)

(or) WIFE of  
 (Husband's name in full)

12 AGE 89 Years 4 Months 9 Days If under 24 hours  
 Hours Minutes

13 Usual Occupation retired custodian  
 (Kind of work done during most of working life)

14 Industry  
 or Business:

15 Social Security No. 012-16-9719

16 BIRTHPLACE (City) unknown  
 (State or country) Sweden

17 NAME OF FATHER 1st name unk. Jorgenson

18 BIRTHPLACE OF FATHER (City) unknown  
 (State or country) Sweden

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) unknown  
 (State or country) Sweden

21 Informant Georgie T. Brinigion

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED March 4, 1964

VAV

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....



APR 8 1964 AM

RM R-301

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Medical Examiner waived jurisdiction.

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 15 Wave Way Ave.



## STANDARD CERTIFICATE OF DEATH

Registered No.

52

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. John Leonard Staehle  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) 10

(a) Residence, No. 15 Wave Way Ave.  
(Usual place of abode)

St. Winthrop  
(City or town and State)

Length of stay: In place of death.....years.....months. 24 days. In place of residence.....years.....months. 24 days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 3, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
FEB 8, 1964 to MAR 3, 1964  
I last saw him alive on FEB 25, 1964, death is said to  
have occurred on the date stated above, at 2:30 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

Due To natural causes.

Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was disease or injury in any way related to occupation of deceased?  
If so, specify

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 3/4/1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 4, 1964

7 NAME OF FUNERAL DIRECTOR Ernest T. C...

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 5 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN single

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years Months 24 Days 13 Usual Occupation (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City) Winthrop  
(State or country) Mass.

17 NAME OF FATHER George Lee Staehle

18 BIRTHPLACE OF FATHER (City) Norfolk  
(State or country) Virginia

19 MAIDEN NAME OF MOTHER Anne Elizabeth Golden

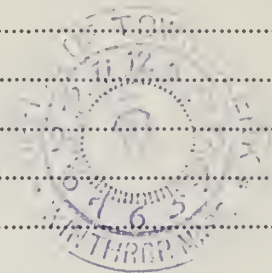
20 BIRTHPLACE OF MOTHER (City) New York  
(State or country) New York

21 Informant George Lee Staehle  
(Address) 15 Wave Way Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:  
Joseph E. Suran (B)  
Health Officer March 4-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....



#### RULES OF PRACTICE

MAR 5 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



PLACE OF DEATH

Suffolk  
(County)

Winthrop

(City or Town)

No. ~~15~~ <sup>15</sup> ~~West~~ Home-104 Highland

## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHTo be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

53

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Francis Louis Perreria  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) no(a) Residence. No. 110 Crest Avenue  
(Usual place of abode)

St. Revere

(If nonresident, give city or town and State)

Length of stay: In place of death 1 years 2 months days. In place of residence 00 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Mar 7 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
19 to 19  
I last saw h alive on 19 death is said to  
have occurred on the date stated above, at 10:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due  
to natural causes.Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Charles Liberman, M. D.

CHARLES LIBERMAN  
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 3/9/1964

6 Harvard Medical Centre-Boston

Place of Burial or Cremation (City or Town)

Date of Burial March 9, 1964

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed MAR 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED or DIVORCED widowed10a If married, widowed or divorced  
HUSBAND of Lillian Quinn  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 88 Years 7 Months 12 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Retired  
(Kind of work done during most of working life)

14 Industry or Business: Cigar-maker

15 Social Security No. 010-09-7119

16 BIRTHPLACE (City) New York  
(State or country) N.Y.

17 NAME OF FATHER Michael Perreria

18 BIRTHPLACE OF FATHER (City) Spain  
(State or country)

19 MAIDEN NAME OF MOTHER Louisa -- CBL.

20 BIRTHPLACE OF MOTHER (City) Spain  
(State or country)21 Informant (Address) Lois Baldwin  
110 Crescent Ave., RevereI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Raef & Serrano (c)  
(Signature of Agent of Board of Health or other)Death Officer March 9, 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance of whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 54

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)

No. 115 Lowell Road

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

1 FULL NAME Rocco John Racana

(If deceased is a married, widowed or divorced woman, give also maiden name.)

115 Lowell Road

Winthrop

{(Was deceased a  
U. S. War Veteran, no  
if so specify WAR.)

(a) Residence. No. (Usual place of abode) St. (City or town and State)

Length of stay: In place of death 10 years months days. In place of residence 10 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 7, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
Feb. 20, 1963, to MARCH 6, 1964  
I last saw him alive on March 6, 1964, death is said to  
have occurred on the date stated above, at 8:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma, generalized

Due To Primary Carcinoma of Lung

(b) Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONSINTERVAL  
BETWEEN  
ONSET AND  
DEATH

9 mos

6 mos

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) John J. Pepi, M.D.

821 Saratoga St., East Boston 3/7 64  
(Address) Date6 Holy Cross Cemetery Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 10 19 64

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAR 9 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED married  
UNKNOWN11 If married, widowed, or divorced Helena Crusco  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 50 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation Inspector  
(Kind of work done during most of working life)

14 Industry or Business M.D.C. Construction Division

15 Social Security No. 032-14-4294

16 BIRTHPLACE (City) Boston, Mass.  
(State or country)

17 NAME OF FATHER John Racana

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Louise DiPasquale

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Helena Racana (wife)

(Address) 115 Lowell Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Rocco J. Racana (R)

(Signature of Agent of Board of Health or other)

Health Officer Mar. 9, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
 CERTIFICATE OF DEATH

Registered No. **55**

{ If death occurred in a hospital or institution,  
 St. { give its NAME instead of street and number }

## PHYSICIAN — IMPORTANT

{ Was deceased a **No**  
 U. S. War Veteran,  
 if so specify WAR }

2 FULL NAME **Ellen Bowman**  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

**8 Kings St.** **66 Winthrop Shore Drive**  
 (a) Residence. No. **66** St. **66**  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. **4** years **4** months **4** days. In place of residence. **4** years **4** months **4** days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **March 11, 1964**  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from  
**March 11, 1964** to **March 11, 1964**  
 I last saw him alive on **March 11, 1964** death is said to  
 have occurred on the date stated above, at **2:50 p.m.**

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Coronary atherosclerosis**  
 (b) Due To **Coronary artery disease**  
 (c) Due To **Coronary artery disease**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
**11 hrs**

OTHER SIGNIFICANT CONDITIONS **arteriosclerosis -**  
**gen**

Was autopsy performed? **no**  
 What test confirmed diagnosis? **no**

5 Was disease or injury in any way related to occupation of deceased? **no**  
 If so, specify

(Signature) **Florence Caspale**, M. D.  
 (Print or Type Name)  
 (Address) **1946 Washington St. #13** **1964**

6 **Winthrop** **Winthrop**  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL **March 14** **1964**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop, Mass**

Received and filed **MAR 13 1964** **19**

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED** **Single**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced  
 HUSBAND of **(Give maiden name of wife in full)**

(or) WIFE of **(Husband's name in full)**

12 AGE **84** Years **84** Months **84** Days  
 If under 24 hours **Hours** **Minutes**

13 Usual Occupation: **Retired**  
 (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.:

16 BIRTHPLACE (City) **Montreal**  
 (State or country) **Canada**

17 NAME OF FATHER **Peter Bowman**

18 BIRTHPLACE OF FATHER (City) **Quebec**  
 (State or country) **Canada**

19 MAIDEN NAME OF MOTHER **Delia B. Robinson**

20 BIRTHPLACE OF MOTHER (City) **Ireland**  
 (State or country)

21 Informant **Florence Caspale**  
 (Address) **31 River Road, Winthrop, Mass**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Joseph B. Scrammi (3)**  
 (Signature of Agent of Board of Health or other)  
**Health Officer** **March 13, 1964**  
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.V.V

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 56

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 51A Harbor View Ave.

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rosamond (Beddeos) Evans  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence, No. 51A Harbor View Ave.  
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 38 years.....months.....days. In place of residence 50 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 11, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....

I last saw h..... alive on....., 19....., death is said to  
have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to  
natural causes, probably

(b) acute coronary occlusion  
on basis of history

(c) OTHER SIGNIFICANT CONDITIONS  
Winthrop Board of Health  
Charles Liberman

Was autopsy performed?  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 3/11/1964

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 13, 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed MAR 12 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of John L Evans  
(Husband's name in full)

12 AGE 58 Years 4 Months 24 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Clerk  
(Kind of work done during most of working life)

14 Industry or Business Manufacturers Agent

15 Social Security No. 019-28-7375

16 BIRTHPLACE (City) Cambridge  
(State or country) Mass.

17 NAME OF FATHER Earl P Beddeos

18 BIRTHPLACE OF FATHER (City) Arlington  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Fanny Brown

20 BIRTHPLACE OF MOTHER (City) Unable to obtain  
(State or country)

21 Informant John L Evans

(Address) 51A Harbor View Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scrammi (a)  
(Signature of Agent of Board of Health or other)

Health officer March 12, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

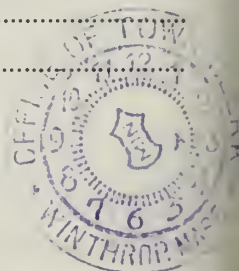
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



MAR 12 1964 PM

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

M.

Gertrude Berkeley (Cashman)

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 820 Saratoga St.  
(Usual place of abode)

St. East Boston, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....13 days. In place of residence.....50 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 13, 1964  
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from March 1, 1964, to March 13, 1964.

I last saw him alive on March 13, 1964 death is said to have occurred on the date stated above, at 11:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) acute congestive heart

(b) failure

(c)

OTHER SIGNIFICANT CONDITIONS removal of diverticulum of esophagus

Was autopsy performed? no

What test confirmed diagnosis? surgery

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) John F. Pepi, M. D.

(Address) East Boston, Mass. 3/14 1964

6 Holy Cross Cemetery, Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 17th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 16 1964 19

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Divorced

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of David F. Berkeley (Husband's name in full)

12 AGE 67 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. 014-22-2095

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Cornelius Cashman

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Mary CBL

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mrs. Mary E. Dolaher-dau. (Address) 820 Saratoga Street, East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

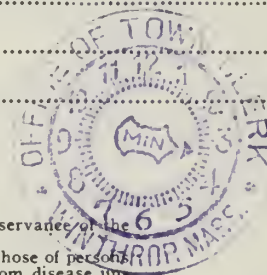
Ralph C. Siranum (3)  
(Signature of Agent of Board of Health or other)Health Officer March 16, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

RECEIVED



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD CERTIFICATE OF DEATH

Registered No. 58

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)

No. 200 Shirley Street

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rebecca Kaplovitz  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

(a) Residence, No. 200 Shirley Street  
(Usual place of abode)

WINTHROP  
(If nonresident, give city or town and State)

Length of stay: In place of death 40 years.....months.....days. In place of residence 40 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....

I last saw him alive on....., 19....., death is said to  
have occurred on the date stated above, at 12:15 A.M.

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to  
natural causes, probably  
(b) acute coronary occlusion on  
(c) basis of history.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

OTHER  
SIGNIFICANT  
CONDITIONS

Winthrop Board of Health  
Charles Liberman M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Charles Liberman M.D.  
CHARLES LIBERMAN  
(Print or Type Name)  
(Address) WINTHROP, MASS Date 3/15 1964

6 Adath Jeshurun West Roxbury  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 16 1964

7 NAME OF FUNERAL DIRECTOR Morris Brezniak

ADDRESS 470 Harvard St., Brookline

Received and filed MAR 16 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☒ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Barnett Kaplovitz  
(Husband's name in full)

12 DATE OF BIRTH  
13 AGE 73 Years.....Months.....Days If under 24 hours  
Hours.....Minutes

14 Usual Occupation: House-wife  
(Kind of work done during most of working life)

15 Industry or Business: At-home

16 Social Security No. No

17 BIRTHPLACE (City) Russia  
(State or country)

18 NAME OF FATHER Gerson Cohen

19 BIRTHPLACE OF FATHER (City) Russia  
(State or country)

20 MAIDEN NAME OF MOTHER Hanna Gerstal

21 BIRTHPLACE OF MOTHER (City) Russia  
(State or country)

22 Informant Mr. George Kaplovitz  
(Address) 151 Cottage Pk. Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Heath Officer (Signature of Agent of Board of Health or other)

(Official Designation) March 16, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

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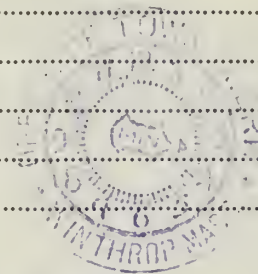
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signature.

Medical Examiner notified and referred to Board of Health.

X

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 59

PLACE OF DEATH

Suffolk  
(County)WINTHROP  
(City or Town)

No. 4 PICO AVE

{ If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number }

PHYSICIAN — IMPORTANT

2 FULL NAME HENRY SCHLAFMAN  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{ (Was deceased a  
U. S. War Veteran,  
if so specify WAR) 10 }

(a) Residence. No. 4 PICO AVE  
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 9 years months days. In place of residence 9 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Dec 1st 1963, to March 15, 1964

I last saw him alive on March 15, 1964, death is said to  
have occurred on the date stated above, at 9:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

(b) Due To coronary arteriosclerosis 15 min

(c) Due To

OTHER SIGNIFICANT CONDITIONS Previous myocardial  
infarction + congestive failure

Was autopsy performed? No

What test confirmed diagnosis? previous cogs

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify No

(Signature) H. B. Greenfield, M. D.

(Address) 447 Shirley St. Date 3-15-64  
Winthrop

6 CHILDREN OF ISRAEL Haverhill  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 16 1964

7 NAME OF FUNERAL DIRECTOR Louis Hyman

ADDRESS Lynn Mass

Received and filed MAR 16 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of SALLY BAKER  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 49 Years 9 Months 8 Days If under 24 hours  
Hours Minutes

13 Usual Occupation MANAGER  
(Kind of work done during most of working life)

14 Industry or Business WALTHAM SUPER MKT

15 Social Security No. 014-10-8015

16 BIRTHPLACE (City) Haverhill  
(State or country) MASS.

17 NAME OF FATHER MAX SCHLAFMAN

18 BIRTHPLACE OF FATHER (City) RUSSIA  
(State or country)

19 MAIDEN NAME OF MOTHER ESTHER - UNKNOWN

20 BIRTHPLACE OF MOTHER (City) RUSSIA  
(State or country)

21 Informant SALLY SCHLAFMAN - WIFE

(Address) 4 PICO AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Serrano (B.)  
(Signature of Agent of Board of Health or other)

Secretary March 14 64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

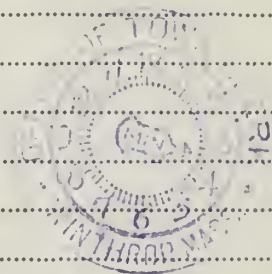
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.





SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

61

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 33 CUTLER

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ARTHUR B. KOSOFSKY  
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a  
U. S. War Veteran, WW II  
if so specify WAR)(a) Residence. No. 33 CUTLER ST.  
(Usual place of abode)St. WINTHROP  
(City or town and State)

Length of stay: In place of death 4 years 6 months days. In place of residence 4 years 6 months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 17 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Sept. 1963 to 3/17/1964  
I last saw him live on 3/17/1964 death is said to  
have occurred on the date stated above, at 11:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma, Rt. Lung 24 yrs.

(b) Due To

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

None.

Was autopsy performed? No

What test confirmed diagnosis Operative and pathology

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M.D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 3/18/1964

6 IF RUTH ISRAEL OF WINTHROP - ENGLAND  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 3-19 1964

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLOV

ADDRESS 1668 BEACON ST., BROOKLYNE

Received and filed MAR 13 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed or divorced  
HUSBAND of RUTH FRIEDMAN  
(Give maiden name of wife in full)(or) WIFE of  
(Husband's name in full)12 AGE 46 Years. Months Days If under 24 hours  
Hours Minutes13 Usual Occupation SALES MANAGER  
(Kind of work done during most of working life)

14 Industry or Business GIBBS MOTOR SALES CO.

15 Social Security No. 028-10-8340

16 BIRTHPLACE (City) MALDEN, MASS.  
(State or country)

17 NAME OF FATHER ISRAEL I. KOSOFSKY

18 BIRTHPLACE OF FATHER (City) RUSSIA  
(State or country)

19 MAIDEN NAME OF MOTHER JENNIE RUTH

20 BIRTHPLACE OF MOTHER (City) RUSSIA  
(State or country)21 Informant MRS. RUTH KOSOFSKY  
(Address) 33 CUTLER ST., WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Strawn (a)  
(Signature of Agent of Board of Health or other)Health officer March 18 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

2/13/41

DATE OF DISCHARGE.....

6/16/45-

RANK, RATING .....

Sgt.

ORGANIZATION AND OUTFIT.....

Hdqts. Co., 53 Armored Infantry

SERVICE NUMBER.....

3101 5550

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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MAR 18 1964 PM



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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 80 Sagamore Ave.



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

# STANDARD CERTIFICATE OF DEATH

Registered No.

62

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

2 FULL NAME Eunice L. Sullivan  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran,  
if so specify WAR) No

(a) Residence, No. 80 Sagamore Ave.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years.....months.....days. In place of residence 20 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 21 - 64  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
NOV-30, 1963, to MARCH 20, 1964

I last saw her alive on 3-20-64, 19, death is said to  
have occurred on the date stated above, at 10:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMATOSIS

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 YRS

Due To (b) PRIMARY INTESTINAL

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

HYPOCHROMIC ANEMIA  
BLOOD LOSS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify N.O.

(Signature) E. J. Caplan, M. D.

A. J. CAPLAN MD  
(Print or Type Name)

(Address) 120 PRINCETON ST. E. BOSTON 3-21, 1964

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 24 19 64

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed MAR 24 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED  
WIDOWED Widowed  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Joseph M. Sullivan  
(Husband's name in full)

12

AGE 66

Years.....Months.....Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation Retired Bookbinder

(Kind of work done during most working life)

14 Industry

or Business: University Press

15 Social Security No. 028-16-8931

16 BIRTHPLACE (City) Boston  
(State or country) Mass

17 NAME OF

FATHER

Robert Patchell

18 BIRTHPLACE OF

FATHER (City)

Boston

(State or country)

Mass

19 MAIDEN NAME

OF MOTHER

Etta C O'Shea

20 BIRTHPLACE OF

MOTHER (City)

Cardiff Wales

(State or country)

England

21 Informant

(Address)

Marie Coulter

79 Highland Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan (2)  
(Signature of Agent of Board of Health or other)

Health Officer  
(Official Designation)

March 23 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MAR 24 1964 PM

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 63

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles Pye (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. 71 Center St. Winthrop St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 19 days. In place of residence 48 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 22, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 56 to March 22, 64 in 1956 to March 22, 1964

I last saw him alive on Mar. 22, 1964, death is said to have occurred on the date stated above, at 12:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE Multiple emboli to cerebrum (a) right upper and right lower extremities and abdomen 3 wks (b) Arteriosclerotic & hyper-tensive heart disease with auricular fibrillation 8 yrs (c) Generalized arteriosclerosis 10 yrs

OTHER SIGNIFICANT CONDITIONS Buerger's disease

Was autopsy performed? no

What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signature) M. Traunstein, Jr., M.D.

(Address) 73 Bartlett Rd. Winthrop, Mass. Mar. 23, 1964

6 Place of Burial or Cremation Winthrop Winthrop (City or Town)

DATE OF BURIAL March 25 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed MAR 23 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of Helen M Johnson (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 67 10 21 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Salesman (Kind of work done during most working life)

14 Industry or Business Paint and Varnish

15 Social Security No. 023-03-0071

16 BIRTHPLACE (City) Wine Harbor (State or country) Nova Scotia

17 NAME OF FATHER Jesse Pye

18 BIRTHPLACE OF FATHER (City) (State or country) Labrador

19 MAIDEN NAME OF MOTHER Nora E Carmichael

20 BIRTHPLACE OF MOTHER (City) (State or country) Shellbourne Nova Scotia

21 Informant (Address) Helen M Pye 71 Center St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: Ralph E. Seranni (Signature of Agent of Board of Health or other) Health Officer March 24 1964 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MAR 24 1964 PM

CERTIFICATE

DEATH

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## The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHTo be filed for burial permit  
with Board of Health  
or its Agent.

Registered No. 64

PLACE OF DEATH

SUT-FOLIS NEWTON  
(County) 47-64WINTHROP  
(City or Town)

No. BOY VIEW NURSING HOME

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FANNIE LOTKIN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 30 KILSYTH RD.  
(Usual place of abode)St. NEWTON  
(If nonresident, give city or town and State)

Length of stay: In place of death. 1 years..... months..... days. In place of residence 3 years..... months..... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAR 23 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
JULY 23, 1963, to MAR 23, 1964  
I last saw her alive on MAR 23, 1964, death is said to  
have occurred on the date stated above, at 5:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LYMPHATIC LYMPHOMA  
GENERALIZEDINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
11 YRS.Due To  
(b)Due To  
(c)

OTHER SIGNIFICANT CONDITIONS GENERAL ARTERIO-SCLEROSIS 1 YR.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL &amp; PATHOLOGICAL

5 Was disease or injury in any way related to occupation of deceased No  
If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING  
(PRINT OR TYPE SIGNATURE)

(Address) 22 PLEASANT ST. Date MAR 24 1964

6 BETH LEVINE W. ROXBURY  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 24 1964

7 NAME OF FUNERAL DIRECTOR ARNOLD GALEO  
ADDRESS 668 BEECH ST BROOKLINE

Received and filed MAR 22 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word)  
MARRIED WIDOWED or DIVORCED10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of ISAAC B. LOTKIN  
(Husband's name in full)11 IF STILLBORN, enter that fact here.  
12 AGE 15 Years..... Months..... Days If under 24 hours  
..... Hours..... Minutes13 Usual Occupation: HOUSEWIFE  
(Kind of work done during most of working life)

14 Industry or Business: AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) LITHUANIA  
(State or country)

17 NAME OF FATHER BARNET TANCHUM

18 BIRTHPLACE OF FATHER (City) LITHUANIA  
(State or country)

19 MAIDEN NAME OF MOTHER SARAH BRENN

20 BIRTHPLACE OF MOTHER (City) LITHUANIA  
(State or country)21 Informant SAMUEL KAPLIN  
(Address) 29 WESTGATE RD NEWTONI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial, or transit permit was issued:Joseph E. Senanue (R)  
(Signature of Agent of Board of Health or other)  
Death Officer March 24, 1964  
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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MAR 24 1964 PM



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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



## The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

65

No.

142 PLEASANT

Winthrop Convalescent Home

(If death occurred in a hospital or institution,  
St. [give its NAME instead of street and number])

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

2 FULL NAME

LOUIS TOMASSI

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

142 PLEASANT

St.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 9 years months days. In place of residence 9 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH

MARCH 23 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

January 30, 1962 to MAR. 23, 1964

I last saw him alive on MAR. 22, 1964, death is said to

have occurred on the date stated above, at 11 A.M.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 DAYS

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

MYOCARDIAL HEART DISEASE 14R

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Louis F. Salerno, M. D.

(Address) 175 Pleasant St Date Mar 23, 1964

6 Holy Cross Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

26 March

1964

7 NAME OF

FUNERAL DIRECTOR

Bisbee &amp; Son

ADDRESS

549 Lincoln Ave. Saugus

MAR 24 1964

Received and filed

19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M.

9 COLOR

W.

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

Widowed

10a If married, widowed, or divorced

HUSBAND of

Antoinette Valeri

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 80 Years 10 Months 0 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation:

Ret. Stone Mason

(Kind of work done during most of working life)

14 Industry

or Business:

Self Employed

15 Social Security No.

030-03-3756

16 BIRTHPLACE (City)

(State or country)

Italy

17 NAME OF  
FATHER

Biagio Tomassi

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

CBL

Theresa Tomassix

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

21

Informant  
(Address)

Mrs. Margaret Castinetti

71 Marshall St. No. Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan (31)

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

145

**EXTRACTS**  
FROM THE LAWS OF THE  
**COMMONWEALTH OF MASSACHUSETTS**  
GOVERNING THE  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION**

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



burial permit  
of Health  
gent.

in plain terms, so that it may be properly classified under the International Classification of Causes  
of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114,  
§§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100H-9-63-936348

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. **7-66**

On Grounds at 308 Main St., Winthrop -(Furlong's  
No. **Service Station**)

Death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **No**

2 FULL NAME **FREDERICK PATRICK FOLEY**  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. **465 Winthrop St., Winthrop** St. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, **30** years.....months.....days. In place of residence **30** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **March 27, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)  
**Arteriosclerotic heart disease.**  
**Diabetes mellitus. (77).**

5 Accident, suicide, or homicide (specify) \_\_\_\_\_  
Date and hour of injury \_\_\_\_\_ 19\_\_\_\_  
IF ACCIDENTAL, was injury causally related to the death? \_\_\_\_\_  
Where did  
injury occur? \_\_\_\_\_  
(City or town and State)  
Did injury occur in or about home, on farm, in industrial place, or in  
public place? \_\_\_\_\_  
(Specify type of place)  
Manner of  
injury \_\_\_\_\_  
(How did injury occur?)  
Nature of  
injury \_\_\_\_\_  
While at work? \_\_\_\_\_ Was autopsy performed? \_\_\_\_\_

6 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
(If so, specify) \_\_\_\_\_  
(Signed) **Michael A. Luongo, M.D.**, M. D.  
(Print or type Name)  
(Address) **Boston** Date **3/27**, 19**64**

7 **St. Joseph Cemetery Boston, Mass**  
Place of Burial or Cremation, (City or Town)

DATE OF BURIAL **March 30**, 19**64**

8 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**  
**Winthrop, Mass.**  
ADDRESS \_\_\_\_\_

Received and filed **MAR 30 1964**, 19\_\_\_\_

A TRUE COPY ATTEST:

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Male** 10 COLOR **White** 11 SINGLE **MARRIED** (write the word)  
**Married**  
WIDOWED  
DIVORCED  
UNKNOWN

12 If married, widowed, or divorced  
HUSBAND of **Anne Molloy Foley**  
(Give maiden name of wife in full)  
(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

13 AGE **65** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If under 24 hours  
Hours \_\_\_\_\_ Minutes \_\_\_\_\_

14 Usual Occupation: **Custodian**  
(Kind of work done during most of working life)

15 Industry or Business: **Town of Winthrop**

16 Social Security No. **025-12-3586**

17 BIRTHPLACE (City) **Worcester**  
(State or country) **Mass**

18 NAME OF FATHER **Patrick Foley**

19 BIRTHPLACE OF FATHER (City) **Worcester**  
(State or country) **Mass**

20 MAIDEN NAME OF MOTHER **Elizabeth Foley**

21 BIRTHPLACE OF MOTHER (City) **Worcester**  
(State or country) **Mass**

22 Informant **Anne Foley**  
(Address)

**465 Winthrop St. Winthrop, Mass**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Siricanni (Co)**  
(Signature of Agent of Board of Health or other)

**Health Officer** **3-30-64**  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death)."

M R-301

burial permit  
of Health  
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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSWINTHROP  
(City or Town making this return)STANDARD  
CERTIFICATE OF DEATH

Registered No. 67

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. 16 SUMMIT AVE

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME AGNES B (McQUADE) CRONIN  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 16 SUMMIT AVE  
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death 25 years.....months.....days. In place of residence 25 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAR 28 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
JAN 3 1964 to MAR 28 1964  
I last saw her live on 3/23 1964, death is said to  
have occurred on the date stated above, at 11:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL INFARCTION 15 MIN  
HYPERTENSIVE AND  
(b) ARTERIO-SCLEROTIC HEART DISEASE SMO  
(c) GENERAL ARTERIO-SCLEROSISINTERVAL  
BETWEEN  
ONSET AND  
DEATH

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 2 YRS

Was autopsy performed? No  
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Myron H. King, M. D.

(Print or Type Name) MYRON H. KING M.D.

(Address) 120 PLEASANT ST WINTHROP DATE 3/30/64

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 30 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed MAR 30 1964

John A. Clark

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of DANIEL J CRONIN  
(Husband's name in full)12 AGE 75 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation HOME MAKER  
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) SOMERVILLE  
(State or country) MASS

17 NAME OF FATHER OWEN A McQUADE

18 BIRTHPLACE OF FATHER (City) BOSTON  
(State or country) MASS

19 MAIDEN NAME OF MOTHER KATHERINE T DWYER

20 BIRTHPLACE OF MOTHER (City) SOMERVILLE  
(State or country) MASS21 Informant WILLIAM G CRONIN  
(Address) 16 SUMMIT AVE WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Serrano (s)  
(Signature of Agent of Board of Health or other)  
Health Officer March 30, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



R-301

burial permit  
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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 68

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP (ON VALESCENT HOME)

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Bridget (Mulkern) Kilmartin  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No(a) Residence, No. 534 Saratoga St. East Boston Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 2 years months days. In place of residence 4 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 28 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
19 to 19.I last saw him alive on 19, death is said to  
have occurred on the date stated above, at 6:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to  
(b) Natural causes, probably(c) acute coronary occlusion on  
basis of past history

OTHER SIGNIFICANT CONDITIONS WINTHROP BOARD OF HEALTH

Was autopsy performed? Charles Liberman M.D.  
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased?  
If so, specify(Signature) Charles Liberman M.D.  
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 3/28/1964

6 Holy Cross Cem. Malden Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 31, 1964

7 NAME OF FUNERAL DIRECTOR Louise L. Penney

ADDRESS 726 Saratoga St. E. Boston

Received and filed MAR 30 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED widow  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Michael Kilmartin  
(Husband's name in full)12 AGE 85 Years 6 Months Days If under 24 hours  
Hours Minutes13 Usual Occupation House work  
(Kind of work done during most of working life)

14 Industry or Business At home

15 Social Security No. None

16 BIRTHPLACE (City) Galway Ireland  
(State or country)

17 NAME OF FATHER Michael Mulkern

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER Mary Green

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

21 Informant Kate Mortimer

(Address) 534 Saratoga St. E. B.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Siranni (S)

(Signature of Agent of Board of Health or other)

Deputy Officer March 30, 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

9-553

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DELIVERY

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 NAME OF FETUS  
(if given)

Baby Boy Pope

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with  
Board of Health or its Agent.

Registered No. 69

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)3 DATE OF  
DELIVERY

March 30, 1964

(Month) (Day) (Year)

4 SEX

Male Female Undetermined

5 COLOR (if

determined)

6 THIS BIRTH (Check one)

Single Twin Triplet

7 IF MULTIPLE BIRTH, BORN:

1st 2nd 3rd

8 FULL  
NAME

Pope, William

FATHER

9 RESIDENCE, NO.

363 Meridian St.

STREET

CITY OR TOWN

East Boston

STATE

Mass

10 COLOR OR  
RACE

W

11 AGE AT TIME OF  
THIS DELIVERY

21

(Years)

12 PLACE OF  
BIRTH

Boston, Mass.

(City or Town)

(State or country)

13

OCCUPATION

Tool &amp; Dye Maker

MOTHER

14 MAIDEN NAME

Lauinger, Ann

PRESENT NAME

Pope, Ann

15 RESIDENCE, NO.

363 Meridian St.

STREET

CITY OR TOWN

East Boston

STATE

Mass

16 COLOR OR  
RACE

W

17 AGE AT TIME OF  
THIS DELIVERY

19

(Years)

18 PLACE OF  
BIRTH

Boston, Mass.

(City or Town)

(State or country)

19

INFORMANT

William Pope

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus)

None

(a) How many children are  
now living?

none

(b) How many children were  
born alive but are now  
dead?

none

(c) How many previous fetal  
deaths of ANY gestation  
age?

None

21 LENGTH OF  
PREGNANCY

21 wks

22 Weight Lb.  
OF FETUS

Oz.

23 WHEN DID FETUS DIE?

Before Labor

During Labor  
or Delivery

24 AUTOPSY

Yes

No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Premature Separation of  
Placenta

Due To (b)

Due To (c)

Prematurity

OTHER SIGNIFICANT  
CONDITIONS

26

Place of Burial or Cremation

Holy Cross Cemetery

(City or Town)

DATE OF BURIAL

April 1

19 64

27 NAME OF  
FUNERAL DIRECTOR

Anthony P. Rapino

ADDRESS

9 Chelsea St., East Boston, Mass.

Received and filed

APRIL 2

1964

(Registrar)

I HEREBY CERTIFY that this delivery occurred on the date stated  
above at 9:45 A.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Louis E Schraffa

M.D.

Louis E Schraffa

(PRINT OR TYPE NAME)

Address 19 Bennington St Date March 30 1964

I HEREBY CERTIFY that a satisfactory certificate of fetal death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sireanni

(Signature of Agent of Board of Health or other)

Health Officer 4-1-64

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



## FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . ."

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

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X  
PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



## The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD

## CERTIFICATE OF DEATH

Registered No. 70

No. Winthrop Convalescent Home (If death occurred in a hospital or institution,  
St. {give its NAME instead of street and number)2 FULL NAME Augusta W (Johnson) Swenson (If deceased is a married, widowed or divorced woman, give also maiden name.)  
(PHYSICIAN - IMPORTANT)  
(Was deceased a U. S. War Veteran, if so specify WAR)(a) Residence. No. 174 Pauline Street St. (If nonresident, give city or town and State)  
(Usual place of abode)

Length of stay: In place of death 14 years months days. In place of residence 57 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 30 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from Dec. 19 53 to March 28 1964  
I last saw her alive on March 28, 1964 death is said to have occurred on the date stated above, at 1:30 a.m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

4 hrs

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Metastatic Cancer from Squamous Cell Cancer of leg

Due To (b) \_\_\_\_\_

Due To (c) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Operation MGH

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify No

(Signed) H. S. Reynolds, M. D.

(Address) 41 Shirley St. Winthrop, Mass. Date 3-30 1964

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 1 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed MAR 30 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED or DIVORCED10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Eric N Swenson (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 1 Months 9 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Sundsall  
(State or country) Sweden

17 NAME OF FATHER John Johnson

18 BIRTHPLACE OF FATHER (City)  
(State or country) Sweden

19 MAIDEN NAME OF MOTHER Emily Einstrom

20 BIRTHPLACE OF MOTHER (City)  
(State or country) Sweden21 Informant Eric Swenson  
(Address) 174 Pauline St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

EXTRACTS  
FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



# The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD CERTIFICATE OF DEATH

Registered No. **71**

PLACE OF DEATH

*Suffolk*  
(County)  
*Waltham*  
(City or Town)



No. *Bay View Nursing Home*

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME *Mary A. Beechcliffe Daley*  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. *144 Cottage Pl. Rd.* St. *Waltham*  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death *1* years *1* months *27* days. In place of residence *10* years *10* months *10* days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *March 31* *1964*  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from *before* 19 *62* to *March 31* 19 *64*  
I last saw her alive on *March 31* 19 *64*, death is said to  
have occurred on the date stated above, at *1:30 P.M.*

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
*2 days*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Bronchopneumonia*  
*terminal*

Due To (b) *Myocardial Heart*  
*Disease*

Due To (c) *Arteriosclerosis gen.*

OTHER SIGNIFICANT CONDITIONS *Senility*

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify

(Signed) *Joseph D. Ward* M. D.

(PRINT OR TYPE SIGNATURE)

(Address) *194 Washington Ave* Date *3-31* 19 *64*

6 *Holy Cross* *Malden, Mass.*  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *Holy Cross April 2 64*

7 NAME OF FUNERAL DIRECTOR *Michael L. Murray*

ADDRESS *265 Beach St. Revere*

Received and filed *MAR 31 1964* 19 *64*

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX *F* 9 COLOR *W* 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED

10a If married, widowed, or divorced  
HUSBAND of *Thomas*  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *86* Years *86* Months *0* Days *0* Hours *0* Minutes

13 Usual Occupation: *Housewife*  
(Kind of work done during most of working life)

14 Industry or Business: *Home*

15 Social Security No.

16 BIRTHPLACE (City) *Boston, Mass.*  
(State or country)

17 NAME OF FATHER *John Daley*

18 BIRTHPLACE OF FATHER (City) *Freland*  
(State or country)

19 MAIDEN NAME OF MOTHER *Juliana Harrington*

20 BIRTHPLACE OF MOTHER (City) *Freland*  
(State or country)

21 Informant *Mrs. George Blaisdell*  
(Address) *64 Cottage Pl. Waltham, Mass.*

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

*Joseph D. Ward* (Signature of Agent of Board of Health or other)

*Health Officer* (Official Designation) *March 31 1964* (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301

Burial permit  
of Health  
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Medical examiner called referred case to Board of Health.

Suffolk

(County)

Winthrop

(City or Town)

No. 5 Coral Ave



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 72

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ann C (Robinson) Elliott  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

5 Coral Ave.

(a) Residence, No. St.  
(Usual place of abode)

(City or town and State)

Length of stay: In place of death, years 6 months days. In place of residence, 7 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 31 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
, 19, to, 19.I last saw h. alive on, 19, death is said to  
have occurred on the date stated above, at 7:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to  
Due to natural causes.(b)  
(c) Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman MD

Was autopsy performed?  
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Charles Liberman M. D.  
CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 4/1/64

6 Woodlawn Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 3 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed APR 3 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Earl E Elliott  
(Husband's name in full)12 AGE 69 Years 2 Months 18 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 012-10-1410

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER William Robinson

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Catherine MacIvor

20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country)

21 Informant Isabel Emery

(Address) Foxboro Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Liberman  
(Signature of Agent of Board of Health or other)  
Heath Liberman April 3, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

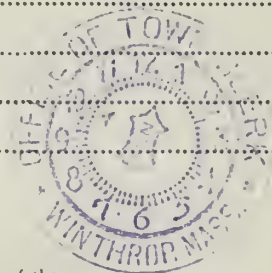
DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

APR 15 1964 AM

R-301

burial permit  
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The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

73

STANDARD  
CERTIFICATE OF DEATH

Registered No. 02264

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)



No. The Boston Floating Hospital, 20 Ash St.

Michael

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Joseph Ferullo

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, if so specify WAR) no

(a) Residence, No. 425 Winthrop Street, Winthrop, Mass. St.

(Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....months 35 days. In place of residence.....years 2 months 24 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 4 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
Feb. 20, 1964 to March 4, 1964I last saw him alive on March 4, 1964, death is said to  
have occurred on the date stated above, at 2:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) OVERWHELMING PNEUMONITIS

Due To CONGENITAL HEART DISEASE

(b)

(c)

OTHER  
SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? PARTIAL CONFIRMATION BY  
GROSS EXAM5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Mary McLaughlin, M. D.

MARTINS HOUSE

(Print or Type Name)

(Address) 20 ASH ST. Date March 4, 1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 7 1964

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston

Received and filed MAR. 9, 1964

William J. Kauer

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED single  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 3 Years 29 Months 29 Days If under 24 hours  
Hours Minutes13 Usual Occupation: none  
(Kind of work done during most of working life)

14 Industry or Business: \*\*\*\*

15 Social Security No. none

16 BIRTHPLACE (City) Boston, Mass.  
(State or country)

17 NAME OF FATHER Pasquale A. Ferullo

18 BIRTHPLACE OF FATHER (City) Winthrop, Mass.  
(State or country)

19 MAIDEN NAME OF MOTHER Gloria Tendo

20 BIRTHPLACE OF MOTHER (City) Boston, Mass.  
(State or country)

21 Informant Pasquale H. Ferullo (father)

(Address) 425 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Donald D. Lorenzo  
(Signature of Agent of Board of Health or other)20904  
(Official Designation)3-5-64  
(Date of Issue of Permit)

TRUE COPY ATTEST:

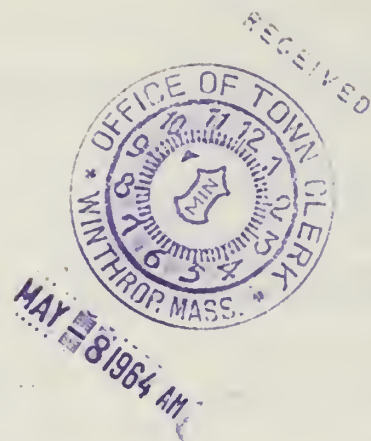
*William J. Kane.*  
City Registrar



APR 30 1964 AM







A TRUE COPY ATTEST:

*William J. Kane*  
City Registrar

R-301

Suffolk

Suffolk

(County)

West Roxbury

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 03105

No. Veterans Administration Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JOSEPH ARTHUR WHEELER

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a **WWI**  
U. S. War Veteran,  
if so specify WAR)

314 Revere St.

Winthrop, Mass.

(a) Residence, No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 0 years 2 months 20 days. In place of residence 27 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 27, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That **VA** attended deceased from  
1/7/64, 1964, to 3/27/64

Death is said to have occurred on the date stated above, at 5:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia

(b) Due To Carcinoma, unknown primary,

(c) Due To ? lung

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
1 MO

yr

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) *Martin E. Linden, Jr.* M. D.  
Martin E. Linden, Jr.

(Print or Type Name)

(Address) VAH, West Roxbury, Mass. 3/27/1964

6 Holy Cross Cemetery, Malden, Mass.

Place of Burial or Cremation

DATE OF BURIAL March 30 1964

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby Funeral

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed

MAR 31 1964

*William J. Kane*  
(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

M

9 COLOR

W

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Hannah A. Carroll

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 65 Years 7 Months 0 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation shipper

(Kind of work done during most of working life)

14 Industry

or Business diving equipment co.

15 Social Security No. 030 05 3813

16 BIRTHPLACE (City)

(State or country) Florence, Mass.

17 NAME OF

FATHER

John Wheeler

18 BIRTHPLACE OF

FATHER (City)

(State or country) Canada

19 MAIDEN NAME

OF MOTHER

Parmelia MacDonald

20 BIRTHPLACE OF

MOTHER (City)

(State or country) Canada

21 Informant Hospital Records

Home (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



RECEIVED



MAY 18 1964 AM

A TRUE COPY ATTEST:

*William J. Kane*  
CITY CLERK

PLACE OF DEATH

SUFFOLK

BOSTON

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

76

(City or Town making this return)

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 03211

No. 294 Bennington St., East Boston (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME HAROLD WEINBERG  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman; give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 43 Floyd Street, Winthrop, Mass.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 31, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CORONARY OCCLUSION

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur?  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?  
(Specify type of place)

Manner of injury  
(How did injury occur?)

Nature of injury  
While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael J. Longo, M.D.

(Print or Type Name)

(Address) Boston Date 3/31/64

7 ONIKCHTY MELROSE  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 1, 1964

8 NAME OF FUNERAL DIRECTOR TORF funeral Service

ADDRESS WASHINGTON Ave Chelsea

Received and filed APR 2 1964

A TRUE William J. Harrington (Attorney)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX M 10 COLOR W 11 SINGLE MARRIED (write the word) WIDOWED WIDOWED DIVORCED UNKNOWN

12 If married, widowed or divorced HUSBAND of DINA H. FREEDMAN (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 59 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: Dealer (Kind of work done during most of working life)

15 Industry or Business: HARDWARE

16 Social Security No.

17 BIRTHPLACE (City) Chelsea Mass (State or country)

18 NAME OF FATHER HARRY Weinberg

19 BIRTHPLACE OF FATHER (City) Russia (State or country)

20 MAIDEN NAME OF MOTHER MARY STONE

21 BIRTHPLACE OF MOTHER (City) Russia (State or country)

22 Informant ALAN WEINBERG (Address) 41 Floyd St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

RECEIVED



MAY 18 1964 AM

A TRUE COPY ATTEST: \

*William J. Kane*  
TOWN CLERK



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. 77

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. Bay View Nursing Home

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)}

### PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

2 FULL NAME Ruth Hoyt Skillings ( Hoyt )  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 306 Revere Street  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death... 16 days. In place of residence... 3 years, 6 months, days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 6, 1961, to April 2, 1964.  
I last saw alive on April 1, 1964 death is said to have occurred on the date stated above, at 4:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Multiple cerebral emboli with  
(a) left hemiplegia 4 wks

Due To (b) Arteriosclerotic & hyper-  
tensive heart disease with  
fibrillation 2 yrs

Due To (c) Generalized arterioscler-  
osis 4 yrs

OTHER SIGNIFICANT CONDITIONS  
Myocardial infarction 1 yr.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

Was autopsy performed? No  
What test confirmed diagnosis Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased NO  
If so, specify

(Signature) M. Traunstein, Jr. M. D.  
(Print or Type Name)

(Address) 73 Bartlett Rd. Winthrop, Mass. April 3, 64

Cliff Cemetery Derby Connecticut  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 4, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh 306 Revere Street Winthrop, Mass.

ADDRESS 174 Winthrop St. Winthrop.

Received and filed APR 3 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) divorced

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Vernon Herbert Skillings (Husband's name in full)

12 AGE 68 Years 0 Months 18 Days If under 24 hours Hours Minutes

13 Usual Occupation: retired Clerk-typist (Kind of work done during most working life)

14 Industry or Business Wholesale milk concern

15 Social Security No. 014-22-2182

16 BIRTHPLACE (City) Shelton Connecticut (State or country)

17 NAME OF FATHER Le Mont Hoyt

18 BIRTHPLACE OF FATHER (City) Derby Connecticut (State or country)

19 MAIDEN NAME OF MOTHER Mary Booth

20 BIRTHPLACE OF MOTHER (City) Waterbury Connecticut (State or country)

21 Informant Mrs. Thelma S. Allen (Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) Health Officer (Date of Issue of Permit) April 3 1964

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

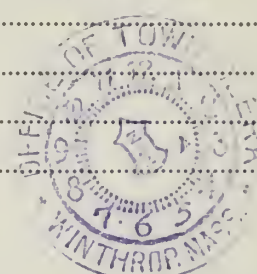
DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **78**

Suffolk  
(County)  
Winthrop  
(City or Town)



Bay View Nursing Home

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Annie Phyllis (Jordan) Tuckerman**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

**24 Perkins Street**

(a) Residence, No. **24 Perkins Street** St. **Winthrop**  
(Usual place of abode) (City or town and State)

Length of stay: In place of death, **1** months, **31** days. In place of residence, **31** years, **0** months, **0** days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 3, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Dec. 1952** to **April 3, 1964**  
I last saw her alive on **April 3, 1964**, death is said to  
have occurred on the date stated above, at **11:00 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Anemia, Nutritional** **6 mos.**

Due To (b) **Hypertensive Coronary** **6 yrs.**

Due To (c) **Artery Heart Disease**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **No**  
What test confirmed diagnosis? **Clinical**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify

(Signature) **Charles Lieberman**, M. D.  
**CHARLES LIEBERMAN**

(Address) **WINTHROP, MASS.** Date **4/4/1964**

**Winthrop** **Winthrop**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **April 6, 1964**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**  
**Winthrop, Mass.**

ADDRESS

Received and filed **APR 6 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED Widowed**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **Charles D Tuckerman**  
(Husband's name in full)

12 AGE **75** Years **0** Months **9** Days If under 24 hours  
Hours Minutes

13 Usual Occupation: **Housewife**  
(Kind of work done during most of working life)

14 Industry or Business: **Own Home**

15 Social Security No. **021-03-7517**

16 BIRTHPLACE (City) **Chicago**  
(State or country) **Ill.**

17 NAME OF FATHER **Charles Jordan**

18 BIRTHPLACE OF FATHER (City) **Swansee**  
(State or country) **Wales**

19 MAIDEN NAME OF MOTHER **Maria Legge**

20 BIRTHPLACE OF MOTHER (City) **Montreal**  
(State or country) **Canada**

21 Informant **Sylvia Baumeister**

(Address) **24 Perkins St. Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Serrano**  
(Signature of Agent of Board of Health or other)

**Secret Office** **April 6, 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include ~~not only~~ deaths caused directly or indirectly by ~~trauma~~ (including ~~resulting~~ septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and ~~persons found dead~~ *persons found dead*.

*Death is caused by*  
*examining*  
*that I fill out the death certificate*  
*to be*  
*quested*  
*Charles H. Hemenway, M.D.*  
Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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Suffolk County

Boston  
(City or Town)KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 03433

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James A. DUNPHY  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran, WW2  
if so specify WARL)(a) Permanent Residence. No. 101 Summit Avenue x Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death years 1 months 1 days. In place of residence years months days Life

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
March 3, 1964, to April 4, 1964death is said to  
have occurred on the date stated above, at 10:38 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) 2 Pancreatitis

Days

(b) Due To Carcinoma of stomach

3 Mos

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Laboratory &amp; Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Hugh F. McCarthy, M. D.  
HUGH F. MC CARTHY MD  
(Print or Type Name)

(Address) VAH, Boston, Mass. Date Apr. 4 1964

6 WINTHROP Cemetery, WINTHROP Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 7, 1964

7 NAME OF FUNERAL DIRECTOR Ernest Caggiano

ADDRESS 147 Winthrop St. Winthrop, Mass.

Received and filed APR 8 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Julia MacArdle  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 59 Years 6 Months 28 Days If under 24 hours  
Hours Minutes13 Usual Occupation Security Guard  
(Kind of work done during most of working life)

14 Industry or Business

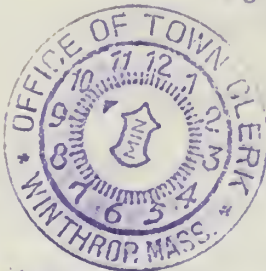
15 Social Security No. 029 01 1177

16 BIRTHPLACE (City) Charlestown  
(State or country)17 NAME OF FATHER Massachusetts  
John DUNPHY18 BIRTHPLACE OF FATHER (City) Prince Edward Island  
(State or country)19 MAIDEN NAME OF MOTHER Canada  
Sarah COSTELLO20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country) Canada21 Informant VA Hospital Records, 150 So.  
Huntington Ave., Boston, Mass.  
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

RECEIVED



MAY 8 1984 AM

A TRUE COPY ATTEST:

*William J. Lane.*

City Registrar



# The Commonwealth of Massachusetts



EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

80

Winthrop Convalescent Home

No.

{(If death occurred in a hospital or institution,  
St. {give its NAME instead of street and number)}

2 FULL NAME Ellen Susan( Card) Nicol

(If deceased is a married, widowed or divorced woman, give also maiden name.)

142 Pleasant St.

(a) Residence. No.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death 3 years months days. In place of residence 5 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec. 1952, to April 4, 1964  
I last saw her alive on 4/3/1964, death is said to have occurred on the date stated above, at 3:45 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

12yr.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized and cerebral arteriosclerosis

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Charles Liberman M. D.

(Address) WINTHROP, MASS Date 4/4/1964

6 Woodlawn Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 6 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed APR 6 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William C Nicol (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 3 Months 15 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Bermuda (State or country)

17 NAME OF FATHER William Card

18 BIRTHPLACE OF FATHER (City) Bermuda (State or country)

19 MAIDEN NAME OF MOTHER Eva Thompson

20 BIRTHPLACE OF MOTHER (City) Bermuda (State or country)

21 Informant Manuila Moore (Address) 24 Chestnut St. N Reading, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sermon Co. (Signature of Agent of Board of Health or other)

Health Officer April 6, 1964 (Official Designation) (Date of Issue of Permit)

50 M-1-58-921876

## EXTRACTS

FROM THE LAWS OF THE

### COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

## RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

## RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

## SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Wintthrop  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. 81

PLACE OF DEATH

Suffolk  
(County)

Wintthrop  
(City or Town)

No. 140 Woodside Avenue

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

### PHYSICIAN — IMPORTANT

2 FULL NAME Manna C. Johnson (Mahlender)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WARI) NO.

(a) Residence. No. 140 Woodside Avenue St.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death. 2 years 6 months days. In place of residence. 87 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 7 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19 to 1964  
I last saw her alive on April 7, 1964, death is said to  
have occurred on the date stated above, at 10:30 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

Due To (b) arteriosclerosis

Due To (c) S. B. 14 y

### OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) M. D.

(Print or Type Name)

(Address) 194 Woodside Ave. Date April 8 1964

6 Wintthrop Cemetery Wintthrop, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 10 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintthrop St. Wintthrop.

Received and filed APR 9 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles W. Johnson  
(Husband's name in full)

12 AGE 87 Years 11 Months 7 Days If under 24 hours  
Hours Minutes

13 Usual Occupation housewife  
(Kind of work done during most working life)

14 Industry or Business own home

15 Social Security No. 011-20-0154

16 BIRTHPLACE (City) Sweden  
(State or country)

17 NAME OF FATHER August Mahlender

18 BIRTHPLACE OF FATHER (City) Sweden  
(State or country)

19 MAIDEN NAME OF MOTHER Alma ?

20 BIRTHPLACE OF MOTHER (City) Sweden  
(State or country)

21 Informant Mr. Alford C. Johnson  
(Address) 140 Woodside Ave. Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan (Signature of Agent of Board of Health or other)

Hereth Officer (Official Designation) April 9 1964 (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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RECEIVED



APR 9 1964 AM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

82

PLACE OF DEATH

SUFFOLK  
(County)WINTHROP  
(City or Town)

No. 22 READ ST

(If death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ANNIE MAE (GADDIS) MOORE  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Residence. No. 22 READ ST  
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 66 years.....months.....days. In place of residence 66 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 9 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....I last saw him alive on ....., 19....., death is said to  
have occurred on the date stated above, at 1:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) natural causes (history  
of hypertension and  
diabetes mellitus).

(c) Due to

INTERVAL  
BETWEEN  
ONSET AND  
DEATHOTHER  
SIGNIFICANT  
CONDITIONS  
Winthrop Board of Health  
Charles Liberman M.D.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN(Address) WINTHROP, MASS. Date 4/9/64  
(Print or Type Name)6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 13 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. IRBY

ADDRESS 210 WINTHROP ST. WINTHROP

Received and filed APR 13 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN MARRIED11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of JAMES MOORE  
(Husband's name in full)12 AGE 69 Years.....Months.....Days If under 24 hours  
.....Hours.....Minutes13 Usual Occupation HOME MAINTENANCE  
(Kind of work done during most of working life)

14 Industry or Business HOME

15 Social Security No.

16 BIRTHPLACE (City) CAMBRIDGE  
(State or country) MASS

17 NAME OF FATHER JAMES GADDIS

18 BIRTHPLACE OF FATHER (City) IRELAND  
(State or country)

19 MAIDEN NAME OF MOTHER ANNIE JENNINGS

20 BIRTHPLACE OF MOTHER (City) ENGLAND  
(State or country)

21 Informant JAMES MOORE

(Address) 22 READ ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Charles E. Liberman (Signature of Agent of Board of Health or other)

Health Officer April 13 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



M R-301

burial permit  
of Health  
Agent.

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TYPE  
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ne last.is contrib-  
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ion given

Medical examiner notified

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Convalescent Home

Angelo Bonura

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

207 Marion Street

(a) Residence, No. (Usual place of abode) St.

East Boston

(City or town and State)

Length of stay: In place of death, 1 years, 9 months, 25 days. In place of residence, 25 years, 9 months, 25 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 10, 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19, to 19,

I last saw him alive on 19, death is said to have occurred on the date stated above, at 3:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due To natural causes.

(c) Due To Winthrop Board of Health

(c) Charles Liberman M.D.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Address) WINTHROP, MASS. Date 4/13/64

6 St. Michael Cemetery Boston (City or Town)

DATE OF BURIAL April 14, 1964

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 15 1964

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 83

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) NO

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED married

11 If married, widowed, or divorced HUSBAND of Rosa Salvaggio (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired (Kind of work done during most of working life)

14 Industry or Business \*\*\*\*\*

15 Social Security No. 012-16-2478

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Liborio Bonura

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Settima Acarda

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Rosa Bonura (wife)

(Address) 207 Marion St., East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Brennan (3)

(Signature of Agent of Board of Health or other)

Health Officer - 4/14/64

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ed for burial perm  
Board of Health  
r its Agent.

STRUCTIONS  
FOR  
AL CERTIFICATE

T OR TYPE  
E OR CAUSES  
F DEATH

not enter  
re than one  
se for each  
, (b) and (c)

does not mean  
ode of dying,  
heart failure,  
etc. It means  
ase, or compli-  
which caused

tions, if any,  
gave rise to  
cause (a),  
g the under-  
cause last.

ditions contrib-  
death but not  
to the terminal  
condition given

Medical examiner notified  
Referred to Board of Health

PLACE OF DEATH

Suffolk

(County)

Winthrop  
(City or Town)

No.

Winthrop Convalescent Home

2 FULL NAME

Angelo Bonura

(If deceased is a married, widowed or divorced woman, give also maiden name.)

207 Marion Street

(a) Residence. No.

(Usual place of abode)

St.

East Boston

(City or town and State)

Length of stay: In place of death 1 years 9 months days. In place of residence 25 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

April 10, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19....., to 19....., to 19....., to 19.....

I last saw h..... alive on 19....., death is said to  
have occurred on the date stated above, at 3:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to

(b) Due to natural causes.

Due To

(c) Winthrop Board of Health  
Charles Liberman M.D.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman M.D.

CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date 4/13/64

6 St. Michael Cemetery Boston  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 14, 1964

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 15 1964

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

### STANDARD CERTIFICATE OF DEATH

Registered No.

83

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX

male

9 COLOR

white

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED married  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Rosa Salvaggio  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 77  
AGE Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Retired  
(Kind of work done during most of working life)

14 Industry or Business \*\*\*\*\*

15 Social Security No. 012-16-2478

16 BIRTHPLACE (City) Italy  
(State or country)

17 NAME OF FATHER Liborio Bonura

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Settima Acarda

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Rosa Bonura (wife)  
(Address) 207 Marion St., East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranno (3)  
Signature of Agent of Board of Health or other

Health Officer - 4/14/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

APR 15 1984 AM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

INSTRUCTIONS  
FOR  
CERTIFICATEgiving  
OF DEATH  
not enter  
than one  
for each  
(b) and (c)does not mean  
of dying,  
heart failure,  
etc. It means  
se, or compli-  
which causedons, if any,  
gave rise to  
cause (a),  
the under-  
cause last.itions contrib-  
death but not  
to the terminal  
condition givenChapter 137,  
1954, requires  
ans to print or  
the cause or  
of death on  
certificates.

c.

100M-11-55-916145

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. MOUNT'S NURSING HOME

2 FULL NAME AGATHA CERBONE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 97 GROVERS AVE.

(Usual place of abode)

Length of stay: In place of death years 2 months days. In place of residence 7 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Apr 10 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Sept 10 1962 to March 30 1964I last saw her alive on March 30 1964 death is said to  
have occurred on the date stated above, at 12 Noon

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) cerebral thrombosis

Due To arteriosclerosis  
(b)Due To  
(c)OTHER  
SIGNIFICANT CONDITIONS Senility

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) H.B. Greenfield, M. D.

(Address) 447 Shattuck St. W. Winthrop Mass. Date 4-10 1964

6 HOLY CROSS CEMETERY, MALDEN, MASS.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL APRIL 13, 1964 19

7 NAME OF FUNERAL DIRECTOR LAWRENCE BRUNO

ADDRESS 291 REVERE ST. REVERE, MASS.

Received and filed APR 13 1964 19

(Registrar)

## The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.

84

STANDARD  
CERTIFICATE OF DEATH

Registered No. ....

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number){ PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, NO  
if so specify WAR)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED MARRIED  
WIDOWED WIDOWED  
or DIVORCED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of PETER CERBONE  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation HOUSEWIFE  
(Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) ITALY  
(State or country)

17 NAME OF FATHER UNKNOWN ZINO

18 BIRTHPLACE OF FATHER (City) ITALY  
(State or country)19 MAIDEN NAME UNKNOWN  
OF MOTHER20 BIRTHPLACE OF MOTHER (City) ITALY  
(State or country)21 Informant MARI GRIECO (DAUGHTER)  
(Address) 97 GROVERS AVENUE, WINTHROP MASS.I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Raeph E. Seranni (B)  
(Signature of Agent of Board of Health or other)Hereth officer April 10, 1964  
(Official Designation) (Date of Issue of Permit)

X

**EXTRACTS**  
FROM THE LAWS OF THE  
**COMMONWEALTH OF MASSACHUSETTS**  
GOVERNING THE  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and four-  
teen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits; or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION** .....

**DATE OF ENTERING MILITARY SERVICE** .....

**DATE OF DISCHARGE** .....

**RANK, RATING** .....

**ORGANIZATION AND OUTFIT** .....

**SERVICE NUMBER** .....



ed for burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

NT OR TYPE  
E OR CAUSES  
F DEATH

o not enter  
ore than one  
ase for each  
, (b) and (c)

does not mean  
ode of dying,  
s heart failure,  
a, etc. It means  
e, or compli-  
-which caused

itions, if any,  
h gave rise to  
e cause (a),  
ng the under-  
cause last.

onditions contrib-  
to death but not  
to the terminal  
condition given

m.b.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 85

PLACE OF DEATH

Suffolk  
(County)1 Winthrop, MASS  
(City or Town)No. Winthrop Hosp.  
Community(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Etta Marcus  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 33 Neptune Ave St. Winthrop  
(Usual place of abode) (City or town and State)

Length of stay: In place of death. 14 years. months. days. In place of residence. 7 years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 11 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
MARCH, 1962 to April 11, 1964  
I last saw her alive on April 11, 1964, death is said to  
have occurred on the date stated above, at 9:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Leukemia, Myeloid

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

24 yrs.

Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

Cerebrovascular Occlusion 1wk.

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS Date 4/12/64

6 Tifereth Israel - Everett  
Place of Burial or Cremation (City or Town)DATE OF BURIAL April 12<sup>th</sup> 1964

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbad

ADDRESS 1668 Beacon St Brookline

Received and filed APR 15 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED married  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Jacob Marcus  
(Husband's name in full)12 AGE 71 Years. Months Days If under 24 hours  
Hours Minutes13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business At Home

15 Social Security No. None

16 BIRTHPLACE (City) Russia  
(State or country)

17 NAME OF FATHER Abraham Shocket

18 BIRTHPLACE OF FATHER (City) Russia  
(State or country)

19 MAIDEN NAME OF MOTHER C.B.H.

20 BIRTHPLACE OF MOTHER (City) Russia  
(State or country)21 Informant Irving Marcus  
(Address) 47 Froquois Rd. ArlingtonI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Joseph S. Sweeney  
(Signature of Agent of Board of Health or other)  
Health Officer 4/12/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

RECEIVED



APR 15 1964 AM

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

for burial permit  
Board of Health  
Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-46.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100R-9-63-936318

PLACE OF DEATH

SUFFOLK

WINTHROP

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 86

No. 189 Shirley Street,

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME BETTY EILEEN LaPOINTE

(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 189 Shirley Street, Winthrop, Mass.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 35 years months days. In place of residence 35 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 15, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Massive pulmonary embolism.

Phlebothrombosis, left leg and thigh. (Postpartum).

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur?  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?  
(Specify type of place)

Manner of injury  
(How did injury occur?)

Nature of injury

While at work? Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Address) Boston (Print or Type Name) Date 4/16 1964

7 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 18 1964

8 NAME OF FUNERAL DIRECTOR Howard S Reynolds  
ADDRESS Winthrop, Mass.

Received and filed APR 17 1964 19

A TRUE COPY ATTEST: (Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR White 11 SINGLE (write the word)  
MARRIED Divorced  
WIDOWED UNKNOWN

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Leo Greenwood  
(Husband's name in full)

13 AGE 35 Years 3 Months 6 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: Machine operator  
(Kind of work done during most of working life)

15 Industry or Business: Box factory  
018-24-2876

16 Social Security No. Boston  
17 BIRTHPLACE (City) Mass.  
(State or country)

18 NAME OF FATHER Richard LaPointe

19 BIRTHPLACE OF FATHER (City) Unable to obtain  
(State or country)

20 MAIDEN NAME OF MOTHER Ethel Scantleberry

21 BIRTHPLACE OF MOTHER (City) England  
(State or country)

22 Informant (Address) Herbert Scantleberry  
40 Pearl Ave. Revere, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siranami  
(Signature of Agent of Board of Health or other)

Health Officer April 17 1964  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE .....  
DATE OF DISCHARGE .....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT .....  
SERVICE NUMBER .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without <sup>Apparent</sup> medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

#### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

ot enter  
than one  
for each  
(b) and (c)

Does not mean  
of dying,  
heart failure,  
etc. It means  
the, or compli-  
which caused

ons, if any,  
have rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
the terminal  
condition given

11 C.

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

STANDARD

CERTIFICATE OF DEATH

Registered No.

87

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No

FRANK CEDER

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

16 WAVE WAY AVE., WINTHROP

(a) Residence. No. (Usual place of abode) St.

(If nonresident, give city or town and State)

Length of stay: In place of death. years. months. 1 days. In place of residence 55 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec 39, 19 to April 20, 1964

I last saw him live on April 20, 1964, death is said to have occurred on the date stated above, at 8:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gastro-Intestinal Hemorrhage, cause undetermined 1 day

(b) Due To (c) Due To

OTHER SIGNIFICANT CONDITIONS Pulmonary Emphysema 15yrs Arterio Sclerotic Heart Disease 10yrs

Was autopsy performed? NO

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

(Signature) Charles Liberman M. D. CHARLES LIBERMAN

(Address) WINTHROP, MASS Date 4/20/64

Tefereth Israel of Winthrop, Everett

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 21, 1964

7 NAME OF FUNERAL DIRECTOR Levine Chapel, Inc.

ADDRESS 470 Harvard St., Brookline

Received and filed APR 21 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of Helen Friedman (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 82 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Salesmen (Kind of work done during most working life)

14 Industry or Business Produce

15 Social Security No. unknown

16 BIRTHPLACE (City) Russia (State or country)

17 NAME OF FATHER Israel Ceder

18 BIRTHPLACE OF FATHER (City) Russia (State or country)

19 MAIDEN NAME OF MOTHER Fromma (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia (State or country)

21 Informant Helen Ceder (Address)

16 Wave Way Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Medical examiner notified of Hosp death within 24 hrs. Declined

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



for burial permit  
ard of Health  
ts Agent.

RUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
e for each  
(b) and (c)

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heart failure,  
etc. It means  
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gave rise to  
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death but not  
o the terminal  
condition given

m.c.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 88

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

No. Bay View Nursing Home

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME

Bessie Gertrude Carstensen (Brown)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(If deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Residence, No. 82 Lowell Road  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death, 8 months, days. In place of residence, 63 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 21 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
JUNE, 1953, to APRIL 21, 1964.  
I last saw her alive on APRIL 21, 1964 death is said to

have occurred on the date stated above, at 10 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL HEMORRHAGE

Due To (b) HYPERTENSION

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONSMYOCARDIAL HEART  
DISEASE + DIABETES

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) Louis F. Salerno, M. D.

(Print or Type Name) LOUISE SALERNO

(Address) WINTHROP, MASS. Date April 23, 1964

6 Winthrop Cemetery, Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 23, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed APR 23 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William A. Carstensen  
(Husband's name in full)12 AGE 87 Years 11 Months 3 Days If under 24 hours  
Hours Minutes13 Usual Occupation: housework  
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No.

16 BIRTHPLACE (City) East Boston  
(State or country) Massachusetts

17 NAME OF FATHER Roscoe Dana Brown

18 BIRTHPLACE OF FATHER (City) Cape Elizabeth  
(State or country) Maine

19 MAIDEN NAME OF MOTHER Thresa Chapman

20 BIRTHPLACE OF MOTHER (City) Damariscotta  
(State or country) Maine21 Informant Deane W. Carstensen  
(Address) Melrose, MassachusettsI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sullivan (31)  
(Signature of Agent of Board of Health or other)  
Health Officer April 23, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

Not enter  
than one  
for each  
(b) and (c)

Does not mean  
of dying,  
heart failure,  
etc. It means  
the, or compli-  
cations which caused

ons, if any,  
have rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
to the terminal  
condition given

m.c.

27-1  
81  
X70

Director  
use only

K Ink.

8 1964

02-932302

OUT-OF-TOWN  
SUFFOLK - OF - TOWN

PLACE OF DEATH

BOSTON

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

99  
(City or Town making this return)

Registered No. 03968

MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Sadie Myers**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) -20

(a) Residence, No. **18 Dolphin Ave.**  
(Usual place of abode)

St. **Winthrop, Mass.**  
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April 21, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from  
**April 20, 1964 to April 21, 1964**

I last saw him alive on **April 21, 1964**, death is said to  
have occurred on the date stated above, at **3:50 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
**Pulmonary embolism.**

(a) **Origin undetermined.**

Due To **Arterio sclerotic**

(b) **cardiovascular disease.**

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **No.**

What test confirmed diagnosis? **Clinical.**

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) **Charles L. Cloy, M.D.**, M. D.

**Charles L. Cloy, M.D.**  
(Print or Type Name)

(Address) **Ass't. Dir., Mass. Gen'l. Hosp.**, Date **April 21, 1964**

6 **Roxbury Memorial Gen Montvale**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Apr 22 - 1964**

7 NAME OF DIRECTOR **Benjamin F. Solomon**

ADDRESS **420 Harvard St. Woburn**

Received and filed **APR 23 1964**

**William J. Kane**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **widowed**

11 If married, widowed, or divorced

HUSBAND of **Berge Myers**  
(Give maiden name of wife in full)

(or) WIFE of **Berge Myers**  
(Husband's name in full)

12 AGE **81** Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation **Housewife**  
(Kind of work done during most working life)

14 Industry or Business **none**

15 Social Security No. **none**

16 BIRTHPLACE (City) **London, England**  
(State or country)

17 NAME OF FATHER **Morris Moscov**

18 BIRTHPLACE OF FATHER (City) **Holland**  
(State or country)

19 MAIDEN NAME OF MOTHER **Esther De Haave**

20 BIRTHPLACE OF MOTHER (City) **Holland**  
(State or country)

21 Informant (Address) **Alvin Myers (Son)**

**33 Ocean Ave Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Donald D. Lawrence**  
(Signature of Agent of Board of Health or other)

**3/16/64**  
(Official Designation)

**4/21/64**  
(Date of Issue of Permit)



RECEIVED



A TRUE

MAY 8 1964 AM

# The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD CERTIFICATE OF DEATH

Registered No. **90**

PLACE OF DEATH

**SUFFOLK**  
(County)

**WINTHROP**  
(City or Town)

No. **MOUNT'S NURSING HOME**

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **RUTH KEYES**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO**

(a) Residence. No. **353 BROADWAY**  
(Usual place of abode)

St. **CHELSEA, MASS.**  
(If nonresident, give city or town and State)

Length of stay: In place of death. **16** years. **40** months. **16** days. In place of residence. **40** years. **40** months. **16** days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **April. 22 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from **Apr 6 62** to **April 22 1964**  
I last saw him alive on **April 22 1964**, death is said to have occurred on the date stated above, at **11:30 A.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Carcinoma of Rectum**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**2 1/2 Y.**

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **NO**

What test confirmed diagnosis? **SURGERY. M.G.H.**

5 Was disease or injury in any way related to occupation of deceased? **NO**  
If so, specify

(Signed) **M. J. GREENFIELD** M. D.

PRINT OR TYPE SIGNATURE

(Address) **1618 Shingler Ave.** Date **4/22/64**

6 **HOLY CROSS CEMETERY MALDEN, MASS.**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **APRIL 24, 1964**

7 NAME OF FUNERAL DIRECTOR **JOHN G. WELSH**

ADDRESS **718 BROADWAY CHELSEA, MASS.**

Received and filed **APR 23 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **FEMALE** 9 COLOR **WHITE** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**or DIVORCED** **WIDOW**

10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **JOSEPH KEYES**  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **76** Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation: **HOUSE WIFE**  
(Kind of work done during most of working life)

14 Industry or Business: **AT HOME**

15 Social Security No.

16 BIRTHPLACE (City) **CHELSEA**  
(State or country) **MASS.**

17 NAME OF FATHER **TIMOTHY J. BURNS**

18 BIRTHPLACE OF FATHER (City) **BOSTON**  
(State or country) **MASS.**

19 MAIDEN NAME OF MOTHER **MARY J. FLEMMING**

20 BIRTHPLACE OF MOTHER (City) **BOSTON**  
(State or country) **MASS.**

21 Informant **CHARLES CURRAN (GRANDSON)**  
(Address) **24 WEBB ST. SALEM, MASS.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Sermon**  
(Signature of Agent of Board of Health or other)

**Health Officer** **April 23 1964**  
(Official Designation) (Date of Issue of Permit)

R-301A

INSTRUCTIONS  
FOR  
CERTIFICATE

giving  
OF DEATH

not enter  
than one  
for each  
b) and (c)

es not mean  
of dying,  
heart failure,  
tc. It means  
or compli-  
which caused

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ve rise to  
ause (a),  
the under-  
ause last.

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eath but not  
the terminal  
dition given

Chapter 137,  
54, requires  
s to print or  
cause or  
of death on  
ificates, and  
48, Acts of  
quires Physi-  
print or type  
er signature.

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



for burial permit  
ard of Health  
ts Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

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for each  
(b) and (c)

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **91**

PLACE OF DEATH

**Suffolk**  
(County)  
**Winthrop**  
(City or Town)



No. **87 Brewster Ave** St. (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Joseph J. Kozak**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) **No**

(a) Residence. No. **87 Brewster Ave** St. (City or town and State)

Length of stay: In place of death **12** years - months - days. In place of residence **12** years - months - days.

3 DATE OF DEATH **April - 22 - 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **Am**, 19 **36**, to **Apr. 20**, 19 **64**.  
I last saw him live on **April 22**, 19 **64**. Death is said to have occurred on the date stated above, at **9:15 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **congestive heart failure**  
(b) **mitral insufficiency** } **9 yrs**  
(c) **Rheumatic heart disease**

OTHER SIGNIFICANT CONDITIONS **mitral insufficiency after mitral valvuloplasty** yrs

Was autopsy performed? **No**  
What test confirmed diagnosis? **operation**  
5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify **No**

(Signature) **H. B. Greenfield**, M. D.  
**H. B. Greenfield**  
(Address) **447 Snider St. Winthrop, Mass.** Date **4-23-64**

**St. Joseph's Cem. Boston**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **April 25 - 1964**

7 NAME OF FUNERAL DIRECTOR **Jos. P. Szulewski**

ADDRESS **93 OTIS ST. Camb.**

Received and filed **APR 23 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **white** 10 SINGLE (write the word) **married**  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced HUSBAND of **Sophie PETRAUKENAS**  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **54** years - Months - Days If under 24 hours Hours - Minutes

13 Usual Occupation **Elev. Operator**  
(Kind of work done during most of working life)

14 Industry or Business **Hotel**

15 Social Security No. **023-07-4613**

16 BIRTHPLACE (City) **Cambridge Mass**  
(State or country)

17 NAME OF FATHER **Stanley Kozak**

18 BIRTHPLACE OF FATHER (City) **Poland**  
(State or country)

19 MAIDEN NAME OF MOTHER **Anna KARPICZ**

20 BIRTHPLACE OF MOTHER (City) **Poland**  
(State or country)

21 Informant **Mrs S. Kozak**  
(Address) **87 Brewster Ave. Wint.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
**Ralph E. Linnell**

(Signature of Agent of Board of Health or other) **Health Officer**  
(Official Designation) **April 23 1964**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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APR 23 1964 AM

For burial permit  
of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
for each  
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death but not  
to the terminal  
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

Maurizio Mele aka  
Maurice Mele

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

15 Cottage St Revere

(a) Residence. No. (Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Apr 22 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 2/27 1964, to 4/22 1964  
I last saw him alive on 4/22 1964, death is said to have occurred on the date stated above, at 7:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Obstructive Carcinoma

Due To Common Duct.

(b) Extending into liver

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Operation 2/22/64

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) H. H. P. M. D.

(Print or Type Name)

(Address) 17A Bennington St Date 4/22 1964

E. Boston Mass.

6 Place of Burial or Cremation St. Michael Cemetery Boston (City or Town)

DATE OF BURIAL April 25 1964

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed APR 27 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 92

((If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

((Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED MARRIED WIDOWED DIVORCED UNKNOWN married

11 If married, widowed, or divorced HUSBAND of Carmela DeMarco (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 70 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired (Kind of work done during most working life)

14 Industry or Business \*\*\*\*\*

15 Social Security No. 028-07-0332

16 BIRTHPLACE (City) (State or country) Italy

17 NAME OF FATHER Joseph Mele

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Carmela Picardi

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Carmela Mele (wife)

(Address) 15 Cottage St., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph S. Seranno (Signature of Agent of Board of Health or other)

Health Officer Apr 25 1964 (Official Designation)

(Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

# RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

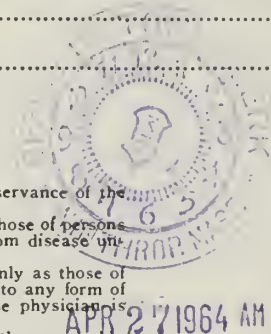
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(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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For burial permit  
of Health  
Agent.

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CERTIFICATE

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1

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME. John Scott Reardon  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 41 Upland Rd., Winthrop Mass St.  
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 23 - 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
April 23, 1964 to April 23, 1964  
I last saw him alive on April 23, 1964 death is said to  
have occurred on the date stated above, at 11 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Premature

Due To Marginal placenta praevia  
(b)

Due To Causing anoxia anoxia  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Meloni, M.D.  
CHARLES MELONI M.D.  
(Print or Type Name)

(Address) 45 Bay State St. Boston, Date April 25 1964

6 Holy Cross Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Apr 27 1964

7 NAME OF FUNERAL DIRECTOR Ernest Pellegrino

ADDRESS 147 Winthrop St Winthrop

Received and filed APR 27 1964 19.

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 93

{(If death occurred in a hospital or institution,  
St. } give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE.....Years.....Months.....Days If under 24 hours  
1 Hours.....Minutes

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop Mass.  
(State or country)

17 NAME OF FATHER John J Reardon

18 BIRTHPLACE OF FATHER (City) Chelsea  
(State or country) Mass

19 MAIDEN NAME OF MOTHER Marjorie B. Penholm

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass

21 Informant John J Reardon  
(Address) 41 Upland Rd Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirciano  
(Signature of Agent of Board of Health or other)  
Health officer 4/25/64  
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

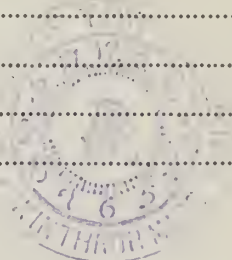
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<p><b>The Commonwealth of Massachusetts</b></p> <p>KEVIN H. WHITE SECRETARY OF THE COMMONWEALTH DIVISION OF VITAL STATISTICS</p>		<p><b>Chelsea</b> (City or Town making this return)</p>
<p><b>COPY OF CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>143</b></p>
<p>1 PLACE OF DEATH</p> <p><b>Suffolk</b> (County)</p> <p><b>Chelsea</b> (City or Town)</p>		
<p>No. <b>U. S. Naval Hospital</b> (If death occurred in a hospital or institution, give its NAME instead of street and number)</p>		
<p>2 FULL NAME <b>John Arthur Hulet</b> (If deceased is a married, widowed or divorced woman, give also maiden name.)</p>		
<p>(a) Residence. No. <b>10 Dolphin Ave.</b> St. <b>Winthrop, Mass.</b> (Usual place of abode) (City or town and State)</p>		
<p>Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.</p>		
<p><b>MEDICAL CERTIFICATE OF DEATH</b></p>		
<p>3 DATE OF DEATH <b>Mar. 8, 1964</b> (Month) (Day) (Year)</p>		
<p>4 I HEREBY CERTIFY That I attended deceased from <b>Mar. 7, 1964</b> to <b>Mar. 8, 1964</b> I last saw him live on <b>Mar. 8, 1964</b>, death is said to have occurred on the date stated above, at <b>12:10 A</b></p>		
<p>DEATH WAS CAUSED BY: IMMEDIATE CAUSE</p> <p>(a) <b>Immaturity</b></p> <p>Due To (b) _____</p> <p>Due To (c) _____</p> <p>OTHER SIGNIFICANT CONDITIONS _____</p>		<p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p>
<p>Was autopsy performed? <b>yes</b></p> <p>What test confirmed diagnosis? _____</p>		
<p>5 Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____</p>		
<p>(Signature) <b>Walter Leo McLean</b>, M. D. <b>U.S. Naval Hospital</b> (Address) <b>Chelsea, Mass.</b> Date <b>Mar. 8, 1964</b></p>		
<p>6 <b>St. Paul Cem., Port Carbon, Pa.</b> Place of Burial or Cremation (City or Town)</p>		
<p>DATE OF BURIAL <b>Mar. 12, 1964</b></p>		
<p>7 NAME OF FUNERAL DIRECTOR <b>E. P. Caggiano &amp; Son</b> ADDRESS <b>147 Winthrop St., Winthrop, Mass.</b></p>		
<p>Received and filed <b>May 4, 1964</b> 19____ (Registrar of City or Town where deceased resided)</p>		
<p><b>PERSONAL AND STATISTICAL PARTICULARS</b></p>		
8 SEX <b>Male</b>	9 COLOR <b>White</b>	10 SINGLE (write the word) <b>Single</b>
<p>11 If married, widowed, or divorced HUSBAND of _____ (Give maiden name of wife in full) (or) WIFE of _____ (Husband's name in full)</p>		
<p>12 AGE.....Years.....Months.....Days <b>12</b> Years <b>8</b> Months <b>8</b> Days</p>		<p>If under 24 hours <b>8</b> Hours <b>0</b> Minutes</p>
<p>13 Usual Occupation: _____ (Kind of work done during most of working life)</p>		
<p>14 Industry or Business: _____</p>		
<p>15 Social Security No. _____</p>		
<p>16 BIRTHPLACE (City) <b>Chelsea, Mass.</b> (State or country)</p>		
<p>17 NAME OF FATHER <b>John Arthur Hulet</b></p>		
<p>18 BIRTHPLACE OF FATHER (City) <b>Port Carbon, Pa.</b> (State or country)</p>		
<p>19 MAIDEN NAME OF MOTHER <b>Sarah J. Lechleitner</b></p>		
<p>20 BIRTHPLACE OF MOTHER (City) <b>Seltzer City, Pa.</b> (State or country)</p>		
<p>21 Informant <b>John Arthur Hulet (Father)</b> <b>10 Dolphin Ave.</b> (Address) <b>Winthrop, Mass.</b></p>		
<p>A TRUE COPY <b>Joseph A. Tyrrell</b></p>		
<p>ATTEST: _____ (Registrar of City or Town where death occurred)</p>		
<p>DATE FILED <b>Mar. 10, 1964</b></p>		

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

#### RULES OF PRACTICE

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THIS IS A PERMANENT RECORD  
 Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

100M-9-63-9363108

The Commonwealth of Massachusetts

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

Danvers

(City or Town making this return)

COPY OF  
 CERTIFICATE OF DEATH

Registered No. 95

PLACE OF DEATH

Essex

(County)

Danvers

(City or Town)

No. Danvers State Hos. Hathorne

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME Catherine Marie Baker

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a no  
 U. S. War Veteran,  
 if so specify WAR)

913 Shirley St.

Winthrop, Mass.

(a) Permanent Residence. No.  
 (Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death 3 years 0 months 15 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF March 30, 1964  
 DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY that I attended deceased from April 30, 1964 to March 30, 1964  
 or March 30, 1964  
 I last saw him alive on March 30, 1964 death is said to have occurred on the date stated above, at 11:40 am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) viral pneumonia

Due To

(b)

Due To

(c)

OTHER  
 SIGNIFICANT  
 CONDITIONS

Generalized

arteriosclerosis

INTERVAL  
 BETWEEN  
 ONSET AND  
 DEATH

yrs

Was autopsy performed?

no

What test confirmed diagnosis?

Clin & Lab.

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Willard M. Hausman

Willard M. Hausman

M. D.

Hathorne, Mass.

(Address) Date 3/30/64

6 Puritan Lawn Mem. Park-Peabody, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL April 2, 1964

7 NAME OF FUNERAL DIRECTOR P.M. Cahill & Son

Peabody, Mass.

ADDRESS

Received and filed MAY 20 1964

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

female

9 COLOR

white

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

Samuel (Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE

65

2

21

If under 24 hours

Years

Months

Days

Hours Minutes

13 Usual Occupation

housewife

(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

032-11-0340

16 BIRTHPLACE (City)

Mass.

(State or country)

17 NAME OF FATHER

Patrick Gillolly

18 BIRTHPLACE OF FATHER (City)

Unknown

(State or country)

Scotland

19 MAIDEN NAME OF MOTHER

Mary Donshoe

20 BIRTHPLACE OF MOTHER (City)

unknown

(State or country)

Ireland

21 Informant

Helen A. Ziolkowski

Danvers, Mass.

(Address)

A TRUE COPY

ATTEST:

Daniel J. Toomey

(Registrar of City or Town where death occurred)

DATE FILED

March 30, 1964

19



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

RECEIVED



MAY 20 1964 AM



MAY 20 1964 AM

for burial permit  
ard of Health  
ts Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
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which caused

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gave rise to  
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the under-  
cause lost.

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death but not  
to the terminal  
condition given

20.1  
81  
70x

19, 1964

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this re:)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 04149

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)



No. BETH ISRAEL HOSPITAL

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME ROSE FELDMAN  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. BAYVIEW NURSING HOME, STURGIS St. WINTHROP  
(Usual place of abode) (City or town and State)

Length of stay: In place of death... years... months... 10 days. In place of residence... 1 years... months... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH APRIL 25, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
APR. 15, 1964 to APR. 25, 1964

I last saw her alive on APRIL 25, 1964, death is said to  
have occurred on the date stated above, at 3:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBROVASCULAR ACCIDENT

Due To ACUTE MYOCARDIAL INFARCTION  
(b)

Due To CORONARY ARTERY DISEASE  
(c)

OTHER SIGNIFICANT CONDITIONS  
DIABETES MELLITUS

Was autopsy performed? NO  
What test confirmed diagnosis? L.P., ECG

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) RONALD T. ROBERT, M. D.

(Address) 330 BROOKLINE AVE. APR. 25, 1964  
(Print or Type Name) Date

6 Onixter Cem Melrose Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 26th, 1964

7 NAME OF FUNERAL DIRECTOR Morris Brezniak

470 Harvard Street, Brookline Mass  
ADDRESS

Received and Filed APR 28 1964  
William J. Seale

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Louis Feldman  
(Husband's name in full)

12 AGE 70 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) Russia  
(State or country)

17 NAME OF FATHER Samuel Gordon

18 BIRTHPLACE OF FATHER (City) Russia  
(State or country)

19 MAIDEN NAME OF MOTHER Libby (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia  
(State or country)

21 Informant Sherman Levenson

24 Green Park Newton Mass.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

26423 8/26/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*

City Registrar

RECEIVED



MAY 19 1964 AM



not for burial permit  
Board of Health  
Agent.INSTRUCTIONS  
FOR  
CERTIFICATEOR TYPE  
OR CAUSES  
DEATHnot enter  
than one  
for each  
(b) and (c)does not mean  
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heart failure,  
etc. It means  
cause, or compli-  
which causedtions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.ditions contrib-  
death but not  
to the terminal  
condition given22.1  
81  
70  
X

OUT - OF - TOWN

SUFFOLK

(County)

1 ROXBURY

(City or Town)

No. JEWISH MEMORIAL HOSPITAL

2 FULL NAME

KATHERINE KEEFE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

57 COTTAGE PARK ROAD WHINTROP

(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 1 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
MARCH 27, 1964 to MAY 1, 1964I last saw her alive on MAY 1, 1964, death is said to  
have occurred on the date stated above, at 5:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY CONGESTION

Due To HYPERTENSIVE AND SCLEROTIC

(b) Due To CARDIO VASCULAR DIS.

(c) OTHER SIGNIFICANT CONDITIONS CEREbro-VASCULAR  
ACCIDENT APHASIA

Was autopsy performed?

NON

What test confirmed diagnosis?

CLINICAL

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Mrs. Ben-Baruch

HERZ BEN-BARUCH M.D.

(Print or Type Name)

(Address) JEWISH MEM. HOSP. Date MAY 1 1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 5, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed MAY 5 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

## CERTIFICATE OF DEATH

Registered No.

04411

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

(City or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of John J. Keefe  
(Husband's name in full)12 AGE 75 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Waltham  
(State or country) Mass

17 NAME OF FATHER Charles J. Harvey

18 BIRTHPLACE OF FATHER (City) Waltham  
(State or country) Mass

19 MAIDEN NAME OF MOTHER Ellen Lanigan

20 BIRTHPLACE OF MOTHER (City) Waltham  
(State or country) Mass.

21 Informant Dorothy Riley

(Address) 207 Woodside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

21267 MAY 5 1964  
(Official Designation) (Date of Issue of Permit)

8700 HORT AVE ST.

*William J. Kroe.*  
CITY CLERK

RECEIVED



MAY 19 1964 AM

for burial permit  
ard of Health  
ts Agent.

CTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
for each  
(b) and (c)

oes not mean  
e of dying,  
heart failure,  
etc. It means  
se, or compli-  
which caused

ons, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
to the terminal  
condition given

N.C.

Death Reported to Medical Examiner and referred to Board of Health.

PLACE OF DEATH

SUFFOLK  
(County)

WINTHROP  
(City or Town)

No. 23 SHIRLEY

2 FULL NAME DEMETRIOS P. BOORAS  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 23 SHIRLEY  
(Usual place of abode)

Length of stay: In place of death 30 years.....months.....days. In place of residence 30 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 3, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....

I last saw h..... alive on ..... 19....., death is said to  
have occurred on the date stated above, at 7:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death - presumably due

Due To to natural causes,

(b) Due To possibly an acute  
(c) coronary occlusion on

OTHER SIGNIFICANT CONDITIONS basis of history  
WINTHROP BOARD of Health

Was autopsy performed? Charles Lieberman M.D. No  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Lieberman, M.D.  
CHARLES LIEBERMAN

(Address) WINTHROP, MASS. Date 5/31 1964

6 WINTHROP CEM. WINTHROP, MASS  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 6, 1964

7 NAME OF FUNERAL DIRECTOR Peter C. HASIOTIS

ADDRESS 642 Commonwealth Ave.  
Boston, Mass.

Received and filed MAY 4 1964

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

### STANDARD CERTIFICATE OF DEATH

Registered No. 98

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

### PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, if so specify WAR) No

St. WINTHROP  
(If nonresident, give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed or divorced  
HUSBAND of PAULINE GEORGOPOULOS  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 76 years..... Months..... Days If under 24 hours  
Hours..... Minutes

13 Usual Occupation: RETIRED  
(Kind of work done during most working life)

14 Industry or Business: IMPORTER-EXPORTER

15 Social Security No. 030-01-3954

16 BIRTHPLACE (City) GREECE  
(State or country)

17 NAME OF FATHER PARASKEVAS BOORAS

18 BIRTHPLACE OF FATHER (City) GREECE  
(State or country)

19 MAIDEN NAME OF MOTHER MARINA XENOS

20 BIRTHPLACE OF MOTHER (City) GREECE  
(State or country)

21 Informant (Address) PAULINE BOORAS

23 SHIRLEY ST. WINTHROP, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sweeney (S)  
(Signature of Agent of Board of Health or other)

Smith officer May 4 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

for burial permit  
ard of Health  
ts Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-936348

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 99

En route to Winthrop Community Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ROCCO

(First Name)

RAUSEO

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran. if so specify WAR) NO

(a) Permanent Residence. No. 155 Everett St., East Boston.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 29 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 13, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CORONARY-ARTERY DISEASE

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did

Injury occur?

(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

(Specify type of place)

Manner of

Injury

Nature of

Injury

While at work? .....Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Leonard Atkins, M.D. Assoc. Med. Exam.

(Print or Type Name)

(Address) 25 Shattuck St. Date 5/14 1964

7 Holy Cross Cemetery Malden

Place of Burial or Cremation.

(City or Town)

DATE OF BURIAL May 16 1964

8 NAME OF FUNERAL DIRECTOR Vincent R. Kapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed MAY 15 1964 19

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR

11 SINGLE (write the word)

male

white

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

married

12 If married, widowed, or divorced Anna Zeoli

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

13 AGE 52

Years.

Months.....

Days

If under 24 hours

AGE

Years.

Months.....

Days

Hours.....Minutes

14 Usual

Occupation:

(Kind of work done during most of working life)

15 Industry

or Business:

R. S. Brine Trans. Co.

16 Social Security No.

022-10-0042

17 BIRTHPLACE (City)

(State or country)

Boston, Mass.

18 NAME OF

FATHER

Antonio Rauseo

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Italy

20 MAIDEN NAME

OF MOTHER

Catherine Cintolo

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Italy

22 Informant

(Address)

Anna Rauseo (wife)

155 Everett St., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seranni (31)  
(Signature of Agent of Board of Health or other)

Health officer  
(Official Designation)

May 15 1964  
(Date of Issue of Permit)

RECEIVED

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

MAY 15 1964 PM

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"



10M-6-62-933404



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF FETAL DEATH  
(STILLBIRTH)

To be filed for burial permit with  
Board of Health or its Agent.

PLACE OF DELIVERY

SUFFOLK  
(County)

WINTHROP  
(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

Registered No. 100

2 NAME OF FETUS  
(if given)

BABY BOY LaVOIE

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

3 DATE OF DELIVERY May 21, 1964  
(Month) (Day) (Year)

4 SEX  
Male.....Female.....Undetermined....

5 COLOR (if determined) W

6 THIS BIRTH (Check one)  
(Single) Twin Triplet

7 IF MULTIPLE BIRTH, BORN:  
1st.....2nd.....3rd.....

8 FULL NAME  
FATHER Joseph R. LaVoie

14 MAIDEN NAME  
MOTHER Clorinda Correale  
PRESENT NAME Clorinda LaVoie

9 RESIDENCE, NO. 3 Everett Court  
CITY OR TOWN East Boston STATE Mass.

15 RESIDENCE, NO. 3 Everett Court  
CITY OR TOWN East Boston STATE Mass.

10 COLOR OR RACE W

11 AGE AT TIME OF THIS DELIVERY 39 (Years)

16 COLOR OR RACE W

17 AGE AT TIME OF THIS DELIVERY 38 (Years)

12 PLACE OF BIRTH Lynn Mass.  
(City or Town) (State or country)

18 PLACE OF BIRTH East Boston Mass.  
(City or Town) (State or country)

13 OCCUPATION

19 INFORMANT Joseph R. LaVoie (father)

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus)

(a) How many children are now living? 2

(b) How many children were born alive but are now dead? none

(c) How many previous fetal deaths of ANY gestation age? one 2 1/2 mo

21 LENGTH OF PREGNANCY completed weeks 36

22 Weight of FETUS 8 Oz.  
(or Grams)

23 WHEN DID FETUS DIE?  
Before Labor During Labor or Delivery Unknown

24 AUTOPSY Yes No

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Unknown

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

26 Holy Cross Cemetery Malden  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL May 27 1964

27 NAME OF FUNERAL DIRECTOR Anthony P. Rapino  
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed 5-26 1964

(Registrar)

A TRUE COPY ATTEST.

I HEREBY CERTIFY that this delivery occurred on the date stated above at 5:07 P.M., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:  
Francis P. Schraffa M.D.

FRANCIS P. SCHRAFFA  
(PRINT OR TYPE NAME)  
Address 101 BENNINGTON ST. Date 5/21 1964  
E. BOSTON

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siuanni (M.D.)  
(Signature of Agent of Board of Health or other)

Health officer 5-26-64  
(Official Designation) (Date of Issue of Permit)

## FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
for each  
(b) and (c)

does not mean  
of dying,  
heart failure,  
etc. It means  
e, or compli-  
which caused

ons, if any,  
have rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
the terminal  
condition given

X  
PLACE OF DEATH

Suffolk

(County)

Winthrop, Mass.

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME

Ellen Merrill (Swimm)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

93 Pleasant Street

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....1.....months.....days. In place of residence.....46.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

June

1

1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from

Jan.

1954

to June 1

1964

I last saw her alive on June 1, 1964, death is said to

have occurred on the date stated above, at 9:05 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DISEASE

Due To (b) AORTIC STENOSIS AND CONGESTIVE HEART FAILURE

(c) PULMONARY EMBOLI

OTHER SIGNIFICANT CONDITIONS PNEUMONIA

Was autopsy performed? YES

What test confirmed diagnosis? autops

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Myron N. King

MYRON N. KING M.D. (Print or Type Name)

(Address) 93 Pleasant St. Winthrop, Mass. Date 6/3/64

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 4, 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JUN 4 1964

(Registrar)

A TRUE COPY ATTEST.

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

101

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
Widow

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George H Merrill

(Husband's name in full)

12

AGE

73

Years

7

Months

2

Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation

Housewife

(Kind of work done during most working life)

14 Industry

or Business

Own home

15 Social Security No.

021-09-1248

16 BIRTHPLACE (City)

Clarke Harbor

(State or country)

Nova Scotia

17 NAME OF

FATHER

Michael Swimm

18 BIRTHPLACE OF

FATHER (City)

Clarke Harbor

(State or country)

Nova Scotia

19 MAIDEN NAME

OF MOTHER

Sarah Smith

20 BIRTHPLACE OF

MOTHER (City)

Clarke Harbor

(State or country)

Nova Scotia

21 Informant

(Address)

Dorothy Merrill

93 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scramme (3)

(Signature of Agent of Board of Health or other)

Health Officer

June 4, 1964

(Official Designation)

(Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

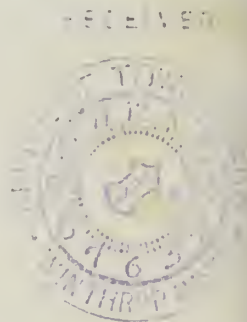
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUN - 4 1964 PM

R-303

for burial permit  
ard of Health  
s Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100K-9-63-936348

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSMEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

102

En route to Winthrop Community Hospital

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)2 FULL NAME PETER MAIOLINO  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Permanent Residence. No. 332 Shirley St., Winthrop St. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death 31 years.....months.....days. In place of residence 31 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 2, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)Arteriosclerotic heart disease. Acute  
congestive heart failure.

5 Accident, suicide, or homicide (specify) \_\_\_\_\_

Date and hour of injury \_\_\_\_\_ 19\_\_\_\_

IF ACCIDENTAL, was injury causally related to the death? \_\_\_\_\_

Where did  
Injury occur? \_\_\_\_\_  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in  
public place? \_\_\_\_\_  
(Specify type of place)Manner of  
Injury \_\_\_\_\_  
(How did injury occur?)Nature of  
Injury \_\_\_\_\_  
While at work? \_\_\_\_\_ Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Michael A. Luongo, M.D., M. D.Boston (Print or Type Name) 6/2 19647 WINTHROP WINTHROP  
Place of Burial or Cremation. (City or Town)DATE OF BURIAL JUNE 5, 19648 NAME OF FUNERAL DIRECTOR JOSEPH RUSSO  
ADDRESS 333 DUDLEY ST. ROX.Received and filed JUN 4 1964 19\_\_\_\_

A TRUE COPY ATTEST: (Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX MALE 10 COLOR WHITE 11 SINGLE MARRIED (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN12 If married, widowed, or divorced ROSINA MELLUSO  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of \_\_\_\_\_  
(Husband's name in full)13 AGE 80 Years.....Months.....Days If under 24 hours  
Hours.....Minutes14 Usual Occupation: RTIRED - ORTHOPEDIC COOBLER  
(Kind of work done during most of working life)15 Industry or Business: SHOPS16 Social Security No. 023-09-568517 BIRTHPLACE (City) AUGUSTA  
(State or country) ITALY18 NAME OF FATHER ANTONIO MAIOLINO19 BIRTHPLACE OF FATHER (City) \_\_\_\_\_  
(State or country) ITALY20 MAIDEN NAME OF MOTHER LUCIA MELLUSO21 BIRTHPLACE OF MOTHER (City) \_\_\_\_\_  
(State or country) ITALY22 Informant (Address) ROSINA MAIOLINO - wife  
332 WINTHROP SHIRLEY ST.  
WINTHROPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Scannini (P)  
(Signature of Agent of Board of Health or other)(Official Designation) Health Officer (Date of Issue of Permit) 6/3/64

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including result of ~~unlabeled~~ <sup>unlabeled</sup> and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"



for burial permit  
Board of Health  
its Agent.

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CERTIFICATE

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DEATH

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

359 Shirley Street

No.

STANDARD  
CERTIFICATE OF DEATH

Registered No.

103

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick M Wentworth

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a WW1  
U. S. War Veteran,  
if so specify WAR)

359 Shirley Street

(a) Residence. No.

(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death. 3 years. months. days. In place of residence. 34 years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 3 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 4-18 1964, to June 2 1964

I last saw him alive on June 2 1964 death is said to have occurred on the date stated above, at 1:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of lung

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? X-Rays Biopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify NO

(Signature) 44-3 Greenfield Field, M. D.

(Print or Type Name)

(Address) 44-3 Greenfield Field Date 6-3 1964

6 Winthrop Winthrop

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 5 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass.

Received and filed JUN 4 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married
---------------	------------------	--

11 If married, widowed, or divorced  
HUSBAND of Edith Ann Nicholson  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE 72 Years 10 Months 20 Days  
If under 24 hours  
Hours Minutes

13 Usual Occupation Laborer  
(Kind of work done during most of working life)

14 Industry or Business Town of Winthrop

15 Social Security No. 011-16-5619

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER Unable to obtain

18 BIRTHPLACE OF FATHER (City) Unable to obtain  
(State or country)

19 MAIDEN NAME OF MOTHER Georgia Wentworth

20 BIRTHPLACE OF MOTHER Belfast  
(State or country) Maine

21 Informant Edith Ann Wentworth  
Winthrop, Mass  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scramm (3)  
(Signature of Agent of Board of Health or other)

Health Officer June 4 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE..... May 2, 1918.....  
 DATE OF DISCHARGE..... Feb. 19, 1919.....  
 RANK, RATING..... Private.....  
 ORGANIZATION AND OUTFIT..... Co D 1st Div. U S Army.....  
 SERVICE NUMBER..... 369112.....

#### RULES OF PRACTICE

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 104

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillian Balkan (Bostwick)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

(a) Residence. No. 20 Taylor St. Winthrop, Mass.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 3 months 3 days. In place of residence 30 years 3 months 3 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 4, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
Jan. 1961 to June 4, 1964  
I last saw her alive on June 3, 1964, death is said to  
have occurred on the date stated above, at 4:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Hemorrhage

Due To (b) Hypertension

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

None

Was autopsy performed?

No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M. D.

(Address) CHARLES LIBERMAN  
(Print or Type Name)  
WINTHROP, MASS. Date 6/4/1964

6 David Vicur Choulm (Lebanon) W. Roxbury  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 7, 1964

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS Brookline, Mass. 420 Harvard Street

Received and filed JUN 4 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN married

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Sidney Balkan

(Husband's name in full)

12 AGE 67 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most working life)

14 Industry or Business: Dress Maker

15 Social Security No. 00-0000000000  
16 BIRTHPLACE (City) Boston, Mass.  
(State or country)

17 NAME OF FATHER Jacob Bostwick

18 BIRTHPLACE OF FATHER (City) Russia  
(State or country)

19 MAIDEN NAME OF MOTHER Anna Cohen

20 BIRTHPLACE OF MOTHER (City) Russia  
(State or country)

21 Informant Sidney Balkan  
(Address) 20 Taylor Street, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan (3)  
(Signature of Agent of Board of Health or other)

Health Officer June 4, 1964  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

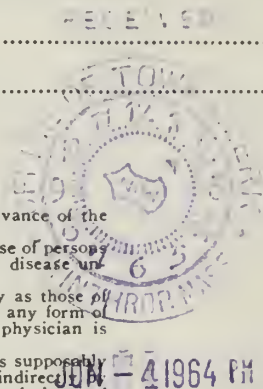
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For burial permit  
of Health  
Agent.

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**The Commonwealth of Massachusetts**  
**KEVIN H. WHITE**  
**SECRETARY OF THE COMMONWEALTH**  
**DIVISION OF VITAL STATISTICS**

(City or Town making this return)

**Suffolk**  
 (County)

**Winthrop, Mass**  
 (City or Town)

**Winthrop Community Hospital**  
 No. \_\_\_\_\_

**STANDARD**  
**CERTIFICATE OF DEATH**

Registered No. **105**

(If death occurred in a hospital or institution,  
 St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Clouise B. Wade (Curry)**  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **31 Lowell** St. **Revere Mass**  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, years **4** months **13** days. In place of residence, years **10** months \_\_\_\_\_ days.

MEDICAL CERTIFICATE OF DEATH			PERSONAL AND STATISTICAL PARTICULARS	
3 DATE OF DEATH <b>June 5 1964</b> (Month) (Day) (Year)	8 SEX <b>Female</b>	9 COLOR <b>white</b>	10 SINGLE (write the word) <b>MARRIED</b> WIDOWED DIVORCED UNKNOWN	
4 I HEREBY CERTIFY, That I attended deceased, from <b>May 19 50</b> to <b>June 5 64</b> I last saw him alive on <b>June 5 1964</b> , death is said to have occurred on the date stated above, at <b>7:30 P.M.</b>			11 If married, widowed, or divorced HUSBAND of _____ (Give maiden name of wife in full) (or) WIFE of <b>Joseph W. Wade</b> (Husband's name in full)	
DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b>			12 AGE <b>50</b> Years <b>4</b> Months <b>28</b> Days If under 24 hours _____ Hours _____ Minutes	
Due To (b) _____			13 Usual Occupation: <b>School Teacher</b> (Kind of work done during most working life)	
Due To (c) _____			14 Industry or Business: <b>Education - Revere School</b>	
OTHER SIGNIFICANT CONDITIONS <b>Metastatic Carcinoma of Lung</b>			15 Social Security No. <b>225-16-1991</b>	
Was autopsy performed? <b>Yes</b>			16 BIRTHPLACE (City) (State or country) <b>Chillicothe West Va.</b>	
What test confirmed diagnosis? _____			17 NAME OF FATHER <b>Abram F. Curry</b>	
5 Was disease or injury in any way related to occupation of deceased? <b>No</b> If so, specify _____			18 BIRTHPLACE OF FATHER (City) (State or country) <b>Kansas U.S.A.</b>	
(Signature) <b>Joseph B. McGorie</b> , M. D. (Print or Type Name)			19 MAIDEN NAME OF MOTHER <b>Iola Marsh</b>	
(Address) <b>194 Washington St. Winthrop</b>			20 BIRTHPLACE OF MOTHER (City) (State or country) <b>West Virginia U.S.A.</b>	
6 <b>Arlington Memorial</b> Arlington, Virginia Place of Burial or Cremation (City or Town)			21 Informant (Address) <b>Joseph W. Wade</b> <b>31 Lowell St. Revere, Mass</b>	
DATE OF BURIAL <b>June 10, 1964</b>				
7 NAME OF FUNERAL DIRECTOR <b>William J. Killion</b>				
ADDRESS <b>1 Sprague Street Revere 51</b>				
Received and filed <b>JUN 9 1964</b>				
(Registrar)			I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued: <b>Joseph B. McGorie</b> (Signature of Agent of Board of Health or other) <b>L. H. Officer</b> June 9, 1964 (Official Designation) (Date of Issue of Permit)	

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE..... 3/27/43  
DATE OF DISCHARGE..... 2/15/46  
RANK, RATING ..... SK 1c  
ORGANIZATION AND OUTFIT..... U.S. Coast Guard Aux (Spars)  
SERVICE NUMBER..... 4009-893

#### RULES OF PRACTICE

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Medical Examiner Notified - referred case to Board of Health

## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.STANDARD  
CERTIFICATE OF DEATH

Registered No. 106

PLACE OF DEATH

Suffolk  
Winthrop  
(County)  
(City or Town)

No. 52 Washington Ave.

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Luca R. Minichino (also known as Louis R. Minichino)

(If deceased a U. S. War Veteran, (if so specify WAR) no

(a) Residence. No. 52 Washington Ave.  
(Usual place of abode)St. Winthrop  
(If nonresident, give city or town and State)

Length of stay: In place of death 5 years months days. In place of residence 5 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw him alive on 19, death is said to have occurred on the date stated above, at 5:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes, probably

(b) Arteriosclerotic heart Disease with heart block

Due To On basis of history

(c) Winthrop Board of Health.

OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Charles Liberman M. D.

CHARLES LIBERMAN  
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 6/9/64

6 St. Michaels Boston Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 13, 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. CACCIANO

ADDRESS 144 Winthrop St. Winthrop

Received and filed JUN 10 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED OR DIVORCED

10a If married, widowed or divorced HUSBAND of MARGARET LUONGO  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 52 Years 7 Months 2 Days If under 24 hours Hours Minutes

13 Usual Occupation: Purchasing Agent  
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No.

16 BIRTHPLACE (City) BOSTON  
(State or country) MASS.

17 NAME OF FATHER DOMENIC MINICHINO

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

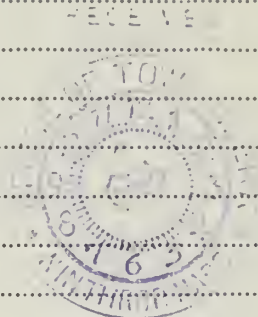
19 MAIDEN NAME OF MOTHER PHILomena ACCOMANDO

20 BIRTHPLACE OF MOTHER (City) ITALY  
(State or country)21 Informant MARGARET MINICHINO  
(Address) 52 WASHINGTON AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scuderi (R)  
(Signature of Agent of Board of Health or other)Health Officer June 10, 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

JUN 10 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

## CERTIFICATE OF DEATH

Registered No. 107

No. 142 Pleasant Street, Winthrop

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gertrude C. O'Connor (Boucha)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, No  
if so specify WAR)

(a) Residence, No. 24 Paine Street, Winthrop  
(Usual place of abode)

(City or town and State)

Length of stay: In place of death, years 3 months 3 days. In place of residence 3 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 11 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
JAN 57, 1957, to JUNE 11, 1964

I last saw her alive on JUNE 8, 1964, death is said to  
have occurred on the date stated above, at 6:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

2 HRS

Due To CORONARY HEART DISEASE  
(b) yja

Due To Atherosclerosis  
(c) yja

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Anthony S. Ripa, M. D.

(Print or Type Name)

(Address) EAST BOSTON Date 12 JUNE 1964

Holy Cross Cemetery, Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 15th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed JUN 12 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Thomas J. O'Connor  
(Husband's name in full)

12 AGE 66 Years 6 Months 25 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Saleslady  
(Kind of work done during most of working life)

14 Industry or Business: Dept. store

15 Social Security No. 010-24-9241

16 BIRTHPLACE (City) Brooklyn N.York  
(State or country)

17 NAME OF FATHER Simon Boucha

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Bridget Burke

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.

21 Informant James O'Connor-son  
(Address) 24 Paine St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)  
Death officer June 12 1964

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

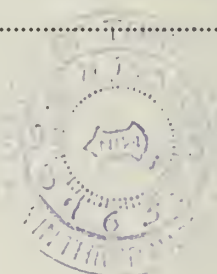
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUN 12 1964 PM

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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME GEORGE F. MURRAY

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 3 ORIENT AVE. E. BOSTON

(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence 20 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 14 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from MAY 16 1964, to JUNE 14 1964

I last saw him live on JUNE 14 1964, death is said to have occurred on the date stated above, at 7:40 p.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) NEPHRO SCLEROSIS +

HYDROCEPHALUS UREMIA

(b) PROSTATIC HYPERTROPHY MARKED

(c) and GENERAL ARTERIO SCLEROSIS

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No.

What test confirmed diagnosis? CLINICAL &amp; x-ray

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Myron N. King, M. D.

myron n. king m.d.

(Print or Type Name)

(Address) 220 Pleasant St. Date 6/14/64

WINTHROP

6 Holy Cross Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 16 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS 315 Chelsea St. E. Boston

Received and filed JUN 15 1964

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 108

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) No.

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 82 Years. Months. Days If under 24 hours Hours. Minutes

13 Usual Occupation Elevator Operator (Kind of work done during most working life)

14 Industry or Business Retired

15 Social Security No. 026-18-3358

16 BIRTHPLACE (City (State or country) EAST Boston MASS.

17 NAME OF FATHER John J. MURRAY

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER MARGARET CONNORS

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Jacqueline D. LEONARD (Address)

177 Woodside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Death Officer June 15 1964 (Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

JUN 15 1964 AM



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 109

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. 1058 Shirley Street

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George Alexander Pulsifer  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence. No. 1058 Shirley Street  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 70 years.....months.....days. In place of residence 70 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Jan. 20, 1958 to June 15, 1964

I last saw him alive on June 14, 1964, death is said to  
have occurred on the date stated above, at 12:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

(a) Acute myocardial infarction 5 hrs

Due To Arteriosclerotic heart  
(b) disease 2 1/2 yrs.

Due To Generalized arterioscler-  
(c) osis 4 yrs.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical and  
laboratory

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Signature) M. Traunstein Jr., M. D.

M. Traunstein, Jr., M.D.

(Address) 73 Bartlett Rd. Winthrop, Mass. 02152  
Date June 16, 1964

6 Winthrop Cemetery Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 18, 1964

7 NAME OF FUNERAL DIRECTOR Clifford B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUN 18 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Eva Lenona Williams  
(Give maiden name of wife in full)

(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

12 AGE 70 Years 7 Months 6 Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: retired grocer  
(Kind of work done during most working life)

14 Industry or Business: retail groceries

15 Social Security No. 011-26-9156

16 BIRTHPLACE (City) Winthrop  
(State or country) Massachusetts

17 NAME OF FATHER Albert Edward Pulsifer

18 BIRTHPLACE OF FATHER (City) Prince Edward Island  
(State or country)

19 MAIDEN NAME OF MOTHER Mary B. Clark

20 BIRTHPLACE OF MOTHER (City) Woods Hole  
(State or country) Massachusetts

21 Informant (Address) Mrs. George A. Pulsifer  
1058 Shirley St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sistianni  
(Signature of Agent of Board of Health or other)

Health Officer  
(Official Designation)

June 17 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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## The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.STANDARD  
CERTIFICATE OF DEATHRegistered No. **110**

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)No. *May View Nursing Home*{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)2 FULL NAME *Joseph Jacobson*  
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT  
{(Was deceased a  
{U. S. War Veteran, *W*  
{if so specify WAR)(a) Residence. No. *418 President Ave* St. *7*  
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death *2* years. months. days. In place of residence *7* years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *June 19, 1964*  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
*August 1962* to *June 19, 1964*  
I last saw him alive on *6/18/64*, 1964, death is said to  
have occurred on the date stated above, at *10:25 A.M.*

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Carcinoma, left lung*INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
*4 mos.*Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS *None*Was autopsy performed? *No*What test confirmed diagnosis? *Clinical*5 Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify(Signed) *Charles Liberman*, M. D.  
*CHARLES LIBERMAN*  
(PRINT OR TYPE SIGNATURE)(Address) *WINTHROP, MASS* Date *6/19/64*6 *Starani* *Starani*  
Place of Burial or Cremation (City or Town) *64*  
DATE OF BURIAL *June 21, 1964*7 NAME OF FUNERAL DIRECTOR *Joy Funeral Home*  
ADDRESS *220 12th St*Received and filed *JUN 19 1964* 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX *Male* 9 COLOR *White* 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED *Widowed*10a If married, widowed, or divorced *Bea K. Liberman*  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

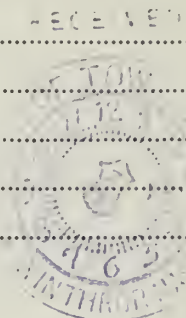
12 AGE *80* Years. Months. Days If under 24 hours  
Hours. Minutes13 Usual Occupation: *Storekeeper*  
(Kind of work done during most of working life)14 Industry or Business: *Retail Food*

15 Social Security No.

16 BIRTHPLACE (City) *Russian*  
(State or country)17 NAME OF FATHER *Bea Jacobson*18 BIRTHPLACE OF FATHER (City) *Russian*  
(State or country)19 MAIDEN NAME OF MOTHER *E. B. L.*20 BIRTHPLACE OF MOTHER (City) *W. Mass*  
(State or country)21 Informant *Manick Liberman*  
(Address) *4 Washington St Boston*I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:  
*Ralph B. Liberman (a)*  
(Signature of Agent of Board of Health or other)*Health Officer* *June 19, 1964*  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
d of Health  
Agent.

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PLACE OF DEATH

Winthrop

(County)

Suffolk

(City or Town)

No. 80 Birch Road



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

# STANDARD CERTIFICATE OF DEATH

Registered No. 111

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

2 FULL NAME ROSE PEARCE(BRAY)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence. No. 41 Tileston Road  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death. 3 years. 1 months. days. In place of residence. 35 years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 19 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
May 19, 1964, to June 19, 1964  
I last saw him alive on June 19, 1964, death is said to  
have occurred on the date stated above, at 1:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Glomerulonephritis with 1 yr.

Due To Uremia.

(b)  
(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

OTHER  
SIGNIFICANT  
CONDITIONS Anemia  
Hypertension

6 mos  
1 yr.

Was autopsy performed? No  
What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 6/20/1964

6 Winthrop Cemetery, Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 22, 1964

7 NAME OF FUNERAL DIRECTOR Clifford B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUN 22 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Albert Ernest Pearce  
(Husband's name in full)

12 AGE 84 Years 1 Months 9 Days If under 24 hours  
Hours Minutes

13 Usual Occupation housewife  
(Kind of work done during most working life)

14 Industry or Business own home

15 Social Security No. 010-05-9197

16 BIRTHPLACE (City) London  
(State or country) England

17 NAME OF FATHER Bray

18 BIRTHPLACE OF FATHER (City) London  
(State or country) England

19 MAIDEN NAME OF MOTHER unable to obtain

20 BIRTHPLACE OF MOTHER (City) London  
(State or country) England

21 Informant Roland H. Pearce  
(Address)

80 Birch Road, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Sherman (R)  
(Signature of Agent of Board of Health or other)

Death Officer June 22, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

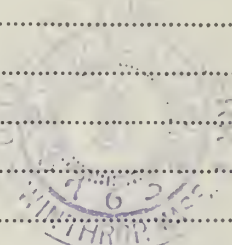
DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



JUN 22 1964 AM

# RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

## STANDARD CERTIFICATE OF DEATH

Registered No. ....

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. Day View Nursing

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Margaret T. Rose nee McGuinness  
(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran,  
if so specify WAR) no 112

(a) Residence, No. 323 Revere St., St. ....  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 1 years, 1 months, 40 days. In place of residence, 40 years, 1 months, 40 days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 20, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
March 30, 1964, to June 20, 1964.

I last saw her alive on June 20, 1964, death is said to  
have occurred on the date stated above, at 9:13 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Emboli

Due To (b) Arteriosclerotic heart disease

Due To (c) Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS  
Hemiplegia, left side  
Hypertension

Was autopsy performed? no

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Signed) John F. Collins M.D., M. D.  
John F. Collins, M.D.  
(Print or Type Name)

(Address) 27 Bennington Street, June 22, 1964  
Revere 51, Mass.

6 St. Marys Lynn  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 23, 1964

7 NAME OF FUNERAL DIRECTOR J. Vincent Murray

ADDRESS Revere Mass

Received and filed June 22 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 CITIZEN OF U.S. YES ☒ NO ☐ 11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced  
HUSBAND of Frank L. Rose (Give maiden name of wife in full)  
(or) WIFE of Frank L. Rose (Husband's name in full)

12 DATE OF BIRTH

13 AGE 80 Years 0 Months 0 Days If under 24 hours  
Hours 0 Minutes

14 Usual Occupation: housewife  
(Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. none

17 BIRTHPLACE (City) Boston Mass.  
(State or country)

18 NAME OF FATHER William McGuinness

19 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

20 MAIDEN NAME OF MOTHER Margaret Roche

21 BIRTHPLACE OF MOTHER (City) Boston Mass.  
(State or country)

22 Informant (Address) Frank L. Rose  
Lynn

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Seriani  
(Signature of Agent of Board of Health or other)  
Health Officer June 22, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

#10031

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

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death but not  
the terminal  
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100.

Medical examiner notified and referred it to Board of Health

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 57 Read

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 113

2 FULL NAME. FRANK E. MCCARTHY (Francis E. McCarthy)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 57 Read St. Winthrop  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 20 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 23, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
, 19, to , 19

I last saw him alive on , 19, death is said to  
have occurred on the date stated above, at 11:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due  
(b) to natural causes.

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman M. D.

(Address) WINTHROP, MASS. Date 6/24/1964

6 Holy Cross, Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 27, 1964

7 NAME OF FUNERAL DIRECTOR Ernest R. Gagliano

ADDRESS 147 Winthrop St., Winthrop

Received and filed JUN 26 1964 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED divorced WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Anna Burke  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE 70 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Mechanist  
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass.

17 NAME OF FATHER Archibald S. McCarthy

18 BIRTHPLACE OF FATHER (City) St. John (State or country) New Brunswick

19 MAIDEN NAME OF MOTHER Elizabeth T. Murphy

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Peter A. McMillan

(Address) 67 Read St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Liberman G.I.  
(Signature of Agent of Board of Health or other)  
Health Officer June 26, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

18  
 JUN 2 6 1964 AM  
 10 7TH AVENUE

for burial permit  
ward of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

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condition given

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

2 FULL NAME

CARLO P. ANNESE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

69 LUBEC

(Usual place of abode)

EAST BOSTON, MASS

(City or town and State)

Length of stay: In place of death.....years.....months.....4.....days. In place of residence.....22.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 28 1964 to June 28 1964

I last saw him alive on June 27, 1964, death is said to have occurred on the date stated above, at 7:40 AM.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia (terminal)  
(b) Cirrhosis of liverDue To  
(c)

OTHER SIGNIFICANT CONDITIONS Cerebro Vascular Degeneration

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph P. Gregoire, M. D.

(Print or Type Name) JOSEPH P. GREGOIRE

(Address) 194 Washington Ave, WINTHROP, MA 02150

6 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 1, 1964

7 NAME OF FUNERAL DIRECTOR DIPIETRO KVAZZA

11 HENRY ST, EAST BOSTON

ADDRESS JUN 29 1964

Received and filed.....19.....

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) NO

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

MALE

9 COLOR

WHITE

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

MARRIED

11 If married, widowed, or divorced

HUSBAND OF EDITH MIRANDA  
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE

52

YEARS

MONTHS

DAYS

HOURS

MINUTES

13

Usual Occupation

WAREHOUSE MAN

(Kind of work done during most of working life)

14

Industry or Business

WHOLESALE GROCERY CO

15

Social Security No.

031-09-0616

16

BIRTHPLACE (City)

BOSTON

(State or country)

MASS

17

NAME OF FATHER

FRANK ANNESE

18

BIRTHPLACE OF FATHER (City)

ITALY

(State or country)

19

MAIDEN NAME OF MOTHER

CHRISTINA UVA

20

BIRTHPLACE OF MOTHER (City)

ITALY

(State or country)

21

Informant

CARL A. ANNESE

(Address)

220 WOODSIDE AVE, WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sericanni (M.D.)

(Signature of Agent of Board of Health or other)

Health Officer

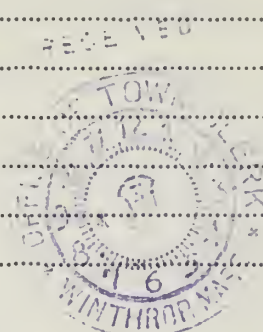
(Official Designation)

6-29-64

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



R-301A

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CERTIFICATE

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F DEATH

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100M-11-55-916145

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. MOUNT NURSING HOME

2 FULL NAME Mary Cullen  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 71 HIGHLAND AVENUE  
(Usual place of abode)St. CHELSEA, MASS.  
(If nonresident, give city or town and State)Length of stay: In place of death 6 years 6 months 6 days. In place of residence 10 years 6 months 6 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 29 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
Jan 1964 to June 29 1964, 1964  
I last saw h. alive on June 29 1964, death is said to  
have occurred on the date stated above, at 01:30 P m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

minutes

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) coronary occlusion  
(myocardial infarction)(b) arteriosclerosis -  
generalized(c) SenilityOTHER  
SIGNIFICANT  
CONDITIONS Carcinoma of  
left breast - post op.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify(Signed) Joseph H. Gregoire M. D.(Address) 194 Washington Ave Date 6/29 1964

6 HOLY CROSS CEMETERY MALDEN, MASS.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 3, 19647 NAME OF FUNERAL DIRECTOR JOHN G. WELSH  
ADDRESS 718 BROADWAY CHELSEA, MASS.Received and filed JUL 2 1964

(Registrar)

## The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHRegistered No. 115{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NOCHELSEA, MASS.  
(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
OR DIVORCED SINGLE

10a If married, widowed, or divorced

HUSBAND of \_\_\_\_\_  
(Give maiden name of wife in full)(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 6 Months 6 Days If under 24 hours  
Hours 6 Minutes13 Usual Occupation: HOUSE WORK  
(Kind of work done during most of working life)14 Industry or Business: AT HOME15 Social Security No. NONE16 BIRTHPLACE (City) BOSTON  
(State or country) MASS.17 NAME OF FATHER WILLIAM CULLEN

18 BIRTHPLACE OF

FATHER (City) \_\_\_\_\_  
(State or country) IRELAND19 MAIDEN NAME OF MOTHER SARAH MOYHAN20 BIRTHPLACE OF MOTHER (City) \_\_\_\_\_  
(State or country) IRELAND21 Informant GERTRUDE CULLEN (SISTER)  
(Address) 71 HIGHLAND AVE. CHELSEA, MASI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Suranum (3)  
(Signature of Agent of Board of Health or other)Health Officer July 1, 1964  
(Official Designation) (Date of Issue of Permit)

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and forty-two, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



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of Health  
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## The Commonwealth of Massachusetts

116

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

## CERTIFICATE OF DEATH

Registered No.

04645

No. Peter Bent Brigham Hospital

((If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James Liotine  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, *No*  
if so specify WAR)

92 Lincoln St.

Winthrop, Mass.

(a) Residence. No.  
(Usual place of abode),

St. Winthrop, Mass.  
(City or town and State)

Length of stay: In place of death, years months 21 days. In place of residence 5 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 9, 1964  
(Month) (Day) (Year)

We HEREBY CERTIFY, That we attended deceased from  
April 18, 1964, to May 9, 1964.  
We last saw him live on May 9, 1964 death is said to  
have occurred on the date stated above, at 6:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphoma

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1 1/2 yrs

(b) Due To

(c) Due To

(d) Due To

(e) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) David D. Ulmer, M. D.  
David D. Ulmer

(Address) PBBH (Print or Type Name) Date May 9, 1964

6 Winthrop Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 12, 1964

7 NAME OF FUNERAL DIRECTOR Ernest Paggianno

ADDRESS 147 Winthrop St Winthrop  
MAY 12 1964

Received and filed William J. Leane 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN MARRIED

11 If married, widowed or divorced  
HUSBAND of Mary Simone  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 63 Years 3 Months 15 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Soldier Dealer  
(Kind of work done during most of working life)

14 Industry or Business Shell Fish

15 Social Security No.

16 BIRTHPLACE (City) Italy  
(State or country)

17 NAME OF FATHER John Liotine

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Katherine Ruggiero

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Mrs Mary Liotine

(Address) 92 Lincoln St Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

1211-125205.

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JUL 21 1964 AM

burial permit  
of Health  
Agent.

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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

117

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 04751

No. ST. ELIZABETH HOSPITAL

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME IRVIN BARKMAN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, NUT  
if so specify WAR)

(a) Residence. No. 106 CIRCUIT 2d St. WINTHROP

(Usual place of abode)

(City or town and State)

Length of stay: In place of death... years... months... 55 days. In place of residence 22 years... months... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 5 - 12 - 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3-20, 1964, to 5-12, 1964.

I last saw him live on 5-12, 1964, death is said to have occurred on the date stated above, at 6:50 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) bladder carcinoma

(b) Due To

(c) Due To

(d) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? biopsy

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) Judith Borit, M. D.

(Print or Type Name) JUDITH BORIT

(Address) H HOSPITAL Date 3-12 1964

6 MILTON CEM. MILTON  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 15 1964

7 NAME OF FUNERAL DIRECTOR Charles P Chapman

ADDRESS 106 CIRCUIT Rd WINTHROP

Received and filed MAY 18, 1964

(Registrar) William J. Kane

A TRUE COPY ATTEST:

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of RUTH C. RASMUSSEN  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 66 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation TEAS.  
(Kind of work done during most of working life)

14 Industry or Business GEN. Ship + ENGINE WORKS. INC.

15 Social Security No. 235-24-5566

16 BIRTHPLACE (City) Rockstar  
(State or country) INDIANA

17 NAME OF FATHER George M. BARKMAN

18 BIRTHPLACE OF FATHER (City) PA.  
(State or country)

19 MAIDEN NAME OF MOTHER SARAH E. Copeland

20 BIRTHPLACE OF MOTHER (City) Ohio  
(State or country)

21 Informant MRS. RUTH C. BARKMAN

(Address) 106 CIRCUIT Rd. WINTHROP, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

RECEIVED



JUL 21 1964 AM



## The Commonwealth of Massachusetts

Essex

Rowley

OFFICE OF THE SECRETARY  
DIVISION OF VITAL STATISTICSCOPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or town making return)

14

Registered No. ....

PLACE OF DEATH

(County)  
Rowley

(City or Town)

Off Haverhill Street

No. .... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William N. Egan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. 16 Maple Road Winthrop, Mass.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 30 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Estimated June 22, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Suicidal death by carbon monoxide  
inhalation

Suicide

Estimated June 22, 64

5 Accident, suicide, or homicide (specify)

Date and hour of injury Body found July 16, 1964

Where did injury occur?  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place?  
(Specify type of place)Manner of injury  
(How did injury occur?)

Nature of injury

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify John J. Pallotta

(Signed) John J. Pallotta M. D.

Village Green, Ipswich July 16, 1964

7 Winthrop Cemetery Winthrop, Mass.  
(City or Town)

DATE OF BURIAL July 20, 1964

8 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS Winthrop, Mass. JUL 22 1964

Received and filed  
(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR OR RACE White 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED married11a If married, widowed or divorced  
HUSBAND of Lillian A. Bourke  
(Give maiden name of wife in full)(or) WIFE of  
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE Bank Accountant If under 24 hours  
Years Months Days Hours Minutes14 Usual Occupation Banking  
(Kind of work done during most of working life)

15 Industry or Business Freeport, Long Island

16 Social Security No. New York

17 BIRTHPLACE (City)  
(State or country) Charles E. Egan

18 NAME OF FATHER New York, N. Y.

19 BIRTHPLACE OF FATHER (City)  
(State or country) Mary T. Murphy

20 MAIDEN NAME OF MOTHER New York, N. Y.

21 BIRTHPLACE OF MOTHER (City)  
(State or country) Mrs. Lillian A. Bourke22 Informant  
Address 16 Maple Road, Winthrop, Mass.

A TRUE COPY.

ATTEST: Edward F. MacDonnell  
(Registrar of City or Town where death occurred)

DATE FILED July 17 1964

#3467

11-22-13-64

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

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JUL 22 1964 AM



For burial permit  
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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

119

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WARI)

2 FULL NAME Fullerton, Frances Maria  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 163 Pleasant  
(Usual place of abode)

St. Winthrop  
(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY 1 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
APRIL 1963, to JULY 1, 1964  
I last saw him live on JULY 1, 1964, death is said to  
have occurred on the date stated above, at 10:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA RT. FEMUR

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1 YR.

Due To GENERALIZED METASTASES

(b) ESPECIALLY BOTH LUNGS

3 YR.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? OPERATION & X-RAYS

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Myron N. King, M. D.

MYRON N. KING M.D.  
(Print or Type Name)

(Address) 211 Pleasant St. Date 7/1 1964

CREMATION Woodlawn Crematory, Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 9 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop.

Received and filed JUL 2 1964 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Douglas Fullerton  
(Husband's name in full)

12 AGE 43 Years 1 Months 4 Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: housewife  
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No. 064-16-8472

16 BIRTHPLACE (City) New York City  
(State or country) New York

17 NAME OF FATHER Frank Riccobono

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Lucy Mazzerella

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Douglas Fullerton  
(Address) 163 Pleasant St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Surran (S)

(Signature of Agent of Board of Health or other)

Health Officer  
(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL - 2 1964 PM

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 120

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,  
St. (If give its NAME instead of street and number)2 FULL NAME Mary Nelson  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

(a) Residence. No. 11 Vaughn Ave. Newton Highlands, Winthrop  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 9 days. In place of residence, 3 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 22, 1964 to July 1, 1964.

I last saw him alive on June 30, 1964 death is said to have occurred on the date stated above, at 230 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart disease

(b) Anteriosclerotic heart

(c) Disease.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

12 hrs

10 yrs

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph Zambella M. D.

(Print or Type Name) Joseph Zambella, M.D.

(Address) 324 Summer St. Boston 19

6 Holy Cross July 1, 64  
Place of Burial or Cremation MAIDEN  
(City or Town)

DATE OF BURIAL July 3 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS East Boston, Mass.

Received and filed JUL 2 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William F. Nelson (Husband's name in full)

12 AGE 87 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Chief Operator (Kind of work done during most working life)

14 Industry or Business Retired

15 Social Security No. CNBL

16 BIRTHPLACE (City) Boston, MASS (State or country)

17 NAME OF FATHER Cornelius REGAN

18 BIRTHPLACE OF FATHER (City) UNKNOWN (State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) UNKNOWN (State or country)

21 Informant Mary Robertson (Address)

11 Vaughn Ave. Newton Highlands

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Linnanni (mark)

(Signature of Agent of Board of Health or other)

Health Officer 7-2-64 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



JUL - 21964 PM



## COPY OF CERTIFICATE OF DEATH

121

## CERTIFICATE OF DEATH

STATE OF NEW HAMPSHIRE

TOWN OR CITY

CLERK'S NO. 41

1. NAME OF DECEASED (TYPE OR PRINT) George H. Sawyer			2. DATE OF DEATH July 1, 1964		
3. PLACE OF DEATH A. COUNTY Carroll			4. USUAL RESIDENCE A. STATE Mass B. COUNTY Suffolk		
B. CITY OR TOWN Conway		C. LENGTH OF STAY (IN THIS PLACE) 1 day	C. CITY OR TOWN Winthrop		
D. FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Memorial Hospital			D. STREET (IF RURAL, GIVE LOCATION) ADDRESS 30 Lewis Ave		E. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. NAME OF HUSBAND OR WIFE (MAIDEN NAME IF WIFE) Gertrude Hill		
9. DATE OF BIRTH Nov. 27, 1891	10. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	11A. USUAL OCCUPATION (KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Clerk		11B. KIND OF BUSINESS OR INDUSTRY Warehouse
12. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) Millbridge Maine		13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. FATHER'S NAME William Sawyer	
15. MOTHER'S MAIDEN NAME Gertrude A. Strout			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES OF SERVICE) No None		17. SOC. SEC. NO. -002-10-5969
18A. INFORMANT Ellsworth Sawyer			18B. ADDRESS 25 Edward Ave., Lynnfield, Mass.		
19. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) Asthma, Bronchial DUE TO (B) Allergy, unspecified DUE TO (C) CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (A), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(A) Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 6 years 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			21B. DESCRIBE HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II OF ITEM 19.)		
25. FUNERAL DIRECTOR'S SIGNATURE Alfred B. Marsh			ADDRESS Winthrop, Mass.		COUNTERSIGNED-AGENT (CITY & STATE OF HEALTH) DATE
DATE REC'D BY TOWN OR CITY CLERK July 3, 1964		CLERK'S OWN SIGNATURE Henry E. Hill		CLERK OF Conway, N.H.	

A true copy, Attest: Hazel E. Stanley, Deputy Clerk of Conway, Dated July 3, 1964

RECEIVED



JUL - 6 1964 AM

For burial permit  
Board of Health  
Agent.

DUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
R CAUSES  
EATH

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The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 122

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. Winthrop Community Hospital (If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME. Vatalaro, Anthony  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 231 Gladstone St.  
(Usual place of abode)

East Boston

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1 - 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
June 10, 1964, to July 1, 1964

I last saw him alive on July 1, 1964, death is said to  
have occurred on the date stated above, at 11:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute pulmonary infarction Sudden

Due To Coronary Thrombosis

(b) Arteriosclerotic heart disease

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes.  
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify unknown

(Signature) Charles Meloni, M. D.  
45 Baywater St. E Boston  
(Address) C. CHARLES MELONI, M.D. Date July 2, 1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 6, 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Baggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed JUL 6 1964 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of Marie Vecchio  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE 67 Years 7 Months 11 Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation Laborer  
(Kind of work done during most working life)

14 Industry or Business Construction

15 Social Security No. 031-01-8793

16 BIRTHPLACE (City) Italy  
(State or country)

17 NAME OF FATHER ONOFRIO  
Grazio Vatalaro

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Rose Russo

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Mrs. Maria Vatalaro  
(Address) 231 Gladstone St E Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seriani (M.D.)  
(Signature of Agent of Board of Health or other)

Health Officer July 8 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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RECEIVED



JUL - 6 1964 PM

## The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit with  
Board of Health or its Agent.CERTIFICATE OF FETAL DEATH  
(STILLBIRTH)

Registered No. 123

PLACE OF DELIVERY

1

Suffolk  
(County)Winthrop  
(City or Town)

No. Winthrop Community Hospital

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)2 NAME OF FETUS  
(if given)

Babyboy Piro

3 DATE OF  
DELIVERY7 - 6 - 64  
(Month) (Day) (Year)

4 SEX

Male ☒ Female ☐ Undetermined ☐

5 COLOR (if

determined) W

6 THIS BIRTH (Check one)

Single ☒ Twin ☐ Triplet ☐

7 IF MULTIPLE BIRTH, BORN:

1st 2nd 3rd

## FATHER

8 FULL  
NAME

Donald J Piro

9 RESIDENCE, NO.

92 White

STREET

CITY OR TOWN

East Boston

STATE

Mass

10 COLOR OR  
RACE

White

11 AGE AT TIME OF  
THIS DELIVERY

25 (Years)

12 PLACE OF  
BIRTH

Boston

Mass  
(City or Town) (State or country)

13

OCCUPATION Sales Office Supervisor

## MOTHER

14 MAIDEN NAME

Mary Anne Ricciardelli

PRESENT NAME

Mary Anne Piro

15 RESIDENCE, NO.

92 White

STREET

CITY OR TOWN

East Boston

STATE

Mass

16 COLOR OR  
RACE

White

17 AGE AT TIME OF  
THIS DELIVERY

21 (Years)

18 PLACE OF  
BIRTH

Revere

Mass  
(City or Town) (State or country)

19

INFORMANT Mary Anne Ricciardelli

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus)

none

(a) How many children are  
now living?

none

(b) How many children were  
born alive but are now  
dead?

none

(c) How many previous fetal  
deaths of ANY gestation  
age?

none

21 LENGTH OF  
PREGNANCY  
completed weeks

37 wks

22 Weight Lb. 9 Oz.  
OF FETUS  
(or Grams)23 WHEN DID FETUS DIE?  
Before Labor ☒ During Labor ☐  
or Delivery Unknown

24 AUTOPSY

Yes ☒ No ☐

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Stillborn

Due To (b)

(unknown)

Due To (c)

OTHER SIGNIFICANT  
CONDITIONS

26

Woodlawn

Everett Mass

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

July 7

1964

27 NAME OF  
FUNERAL DIRECTOR

Ernest Plaggiano

ADDRESS

147 Winthrop St Winthrop

JUL 7 1964

Mass

Received and filed

19

(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated  
above at 5:30 p.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Louis Eschraffa

M.D.

Louis E Schraffa

(PRINT OR TYPE NAME)

Address

191 Bennington St

Date

July 6 1964

East Boston

I HEREBY CERTIFY that a satisfactory certificate of fetal death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (MCK)

(Signature of Agent of Board of Health or other)

Health Officer

7-7-64

(Official Designation)

(Date of Issue of Permit)

## FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .".

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.



ed for burial permit  
Board of Health  
r its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

T OR TYPE  
OR CAUSES  
OF DEATH

not enter  
re than one  
se for each  
, (b) and (c)

does not mean  
ode of dying,  
s heart failure,  
etc. It means  
ease, or compli-  
which caused

itions, if any,  
gave rise to  
e cause (a),  
g the under-  
cause last.

ditions contrib-  
o death but not  
to the terminal  
condition given

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 124

No. Mount Nursing Home.

((If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anna Digan.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

((Was deceased a  
U. S. War Veteran, NO  
if so specify WAR))

137 Webster St.

East Boston,

(a) Residence. No.  
(Usual place of abode)

St. East Boston,  
(City or town and State)

Length of stay: In place of death, 1 years 2 months days. In place of residence, 50 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 7 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Mar 6, 1960, to July 7, 1964.I last saw her live on June 6, 1964, death is said to  
have occurred on the date stated above, at 3:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Terminal Pneumonia

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

6 days

Due To Arteriosclerosis

(b) Due To Arteriosclerotic Heart Disease

OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? no  
What test confirmed diagnosis? Cholesterol5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Louis E. Schraffa, M. D.

(Address) 19 Pennington St. East Boston Date 7 7 19 64

6 Holy Cross Malden, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 10 19 64

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath.

ADDRESS 325 Chelsea St. East Boston.

Received and filed JUL 8 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female	9 COLOR White	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single
-----------------	------------------	---

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 91 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Clerk  
(Kind of work done during most of working life)

14 Industry or Business Boston Edison Co.

15 Social Security No. C. N. B. E.  
16 BIRTHPLACE (City) East Boston  
(State or country) Mass.

17 NAME OF FATHER Patrick Digan

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER Mary Maginn.

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

21 Informant Arthur Digan

(Address) 137 Webster St. East Boston.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Siricanni (M.D.)  
(Signature of Agent of Board of Health or other)

Health Officer 17-8-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

RECEIVED



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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

JUL - 8 1964

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

T OR TYPE  
OR CAUSES  
DEATH

not enter  
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does not mean  
ode of dying,  
e heart failure,  
, etc. It means  
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cause (a),  
g the under-  
cause lost.

ditions contrib-  
death but not  
to the terminal  
condition given

M.C.

MEDICAL EXAMINER'S DECLINES JURISDICTION

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 125

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WIN. R. F. COMMUNITY HOSPITAL

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

MARY I GOVERN

2 FULL NAME  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 292 Pleasant St., Winthrop  
(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death... years... months... days. In place of residence... years... months... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 10, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 1, 1964, to July 10th, 1964

I last saw him alive on July 10, 1964, death is said to have occurred on the date stated above, at 8:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes.

(b) Probably a cerebral hemorrhage on basis of past history.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed: Charles Liberman M.D.  
What test confirmed diagnosis?5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date 7/11/1964

6 St. Francis Xavier, SO KEVMOVTH.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 13th, 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. MYRBY

ADDRESS WINTHROP, MASS.

Received and filed JUL 13 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of (Husband's name in full)  
12 AGE 71 Years... Months... Days If under 24 hours  
Hours... Minutes13 Usual Occupation: NEWS PAPERS  
(Kind of work done during most working life)

14 Industry or Business: SALESMAN RETIRED

15 Social Security No. 019-28-6105

16 BIRTHPLACE (City) EAST BOSTON  
(State or country) MASS

17 NAME OF FATHER BERNARD J. MCGOVERN

18 BIRTHPLACE OF FATHER (City) EAST BOSTON  
(State or country) MASS

19 MAIDEN NAME OF MOTHER CATHERINE H. SULLIVAN

20 BIRTHPLACE OF MOTHER (City) EAST BOSTON  
(State or country) MASS21 Informant MISS AGNES MCGOVERN  
(Address) 292 PLEASANT ST WINTHROP, MASS

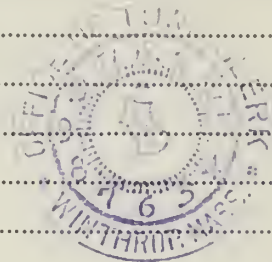
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scrammi (MCK)  
(Signature of Agent of Board of Health or other)Heath Liberman 7-13-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



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RULES OF PRACTICE

JUL 13 1964 AM

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for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
A CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
ie for each  
, (b) and (c)

does not mean  
ode of dying,  
heart failure,  
etc. It means  
ase, or compli-  
which caused

tions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
to the terminal  
condition given

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME. Blanche Giguere Duval

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 193 Pauline St Winthrop

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 30 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 16 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Dec 9, 1962, to July 16, 1964I last saw her alive on July 16, 1964. Death is said to  
have occurred on the date stated above, at 10:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To arteriosclerosis

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Diabetes mellitus

Was autopsy performed?

What test confirmed diagnosis? Ecg.

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify NO

(Signature) H. B. Greenfield, M. D.

H. B. Greenfield (Print or Type Name)

(Address) 447 State St Winthrop Date 7-16-64

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 20 1964

7 NAME OF FUNERAL DIRECTOR MAURILE W NIRBY

ADDRESS WINTHROP MASS.

Received and filed JUL 17 1964

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 126

(If death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of LEON H. DUVAL  
(Husband's name in full)12 AGE 73 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation HOME Housewife  
(Kind of work done during most working life)

14 Industry or Business: OWN HOME

15 Social Security No. NONE  
16 BIRTHPLACE (City) HOLYOKE MASS  
(State or country)

17 NAME OF FATHER JOHN GIGUERE

18 BIRTHPLACE OF FATHER (City) ST ALBANS VT.  
(State or country)

19 MAIDEN NAME OF MOTHER CORA LACOURE

20 BIRTHPLACE OF MOTHER (City) CANADIA  
(State or country)21 Informant LEON DUVAL  
(Address)

193 PAULINE ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sirois (M.D.)  
(Signature of Agent of Board of Health or other)Health Officer 7-17-64  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



JUL 17 1964 AM



INSTRUCTIONS  
FOR  
CERTIFICATEgiving  
OF DEATH

not enter  
than one  
e for each  
(b) and (c)

does not mean  
of dying,  
heart failure,  
etc. It means  
se, or compli-  
which caused

ons, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
to the terminal  
condition given

Chapter 137,  
1954, requires  
ans to print or  
e cause or  
of death on  
rtificates, and  
48, Acts of  
quires Physi-  
print or type  
der signature.

11C.

## The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

STANDARD  
CERTIFICATE OF DEATH

Registered No. 127

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Bay View Nursing Home

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME Mary A. Hurley ( Fitzgerald )

(If deceased is married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 93 Undine Ave.

(Usual place of abode)

St.

(If nonresident, give city or town and State)

Length of stay: In place of death. 9 years. 9 months. 15 days. In place of residence. 15 years. 15 months. 15 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 17 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1962 to July 17 1964

I last saw him alive on July 17 1964, death is said to have occurred on the date stated above, at 7:20 P.M.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease 5 yrs

(b) Generalized ARTERIOSCLEROSIS 10 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS Decubitus Ulcers on legs. 2 yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clin 1041

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles Liberman, M.D.

CHARLES LIBERMAN

(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP MASS Date 7/17/1964

6 Holy Cross Cemetery MAIDEN

Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 20 1964

7 NAME OF FUNERAL DIRECTOR Wm H McKenna

ADDRESS 390 Medford St, Som

Received and filed JUL 21 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Charles J. Hurley

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 8 Months 15 Days If under 24 hours Hours Minutes

13 Usual Occupation: House wk (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.

16 BIRTHPLACE (City) IRELAND (State or country)

17 NAME OF FATHER John Fitzgerald

18 BIRTHPLACE OF FATHER (City) IRELAND (State or country)

19 MAIDEN NAME OF MOTHER NORA C.N.B.C.

20 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

21 Informant MARGARET CARROLL (Address) 93 Undine Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Liberman (Signature of Agent of Board of Health or other)

Health Officer: JUL 18 1964 (Official Designation) (Date of Issue of Permit)

McKenny

SPACE FOR ADDITIONAL INFORMATION ..... RECEIVED  
DATE OF ENTERING MILITARY SERVICE .....  
DATE OF DISCHARGE .....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT .....  
SERVICE NUMBER .....  
.....



JUL 21 1964 AM

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

d for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
e than one  
e for each  
, (b) and (c)

does not mean  
ode of dying,  
heart failure,  
etc. It means  
ase, or compli-  
which caused

tions, if any,  
gave rise to  
cause (a),  
g the under-  
cause last.

ditions contrib-  
to death but not  
to the terminal  
condition given

Medical Examiner waived jurisdiction.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 128

SUFFOLK  
(County)  
WINTHROP  
(City or Town)



No. 70 COTTAGE PARK RD

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME TIMOTHY FRANCIS CARR  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NY

(a) Residence. No. 70 COTTAGE PARK RD  
(Usual place of abode)

St. WINTHROP

(City or town and State)

Length of stay: In place of death, years 1 months 15 days. In place of residence, years 1 months 15 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 18, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
June 10, 1964 to July 18, 1964

Last saw him alive on July 18, 1964, death is said to  
have occurred on the date stated above, at 7:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ~~interstitial pneumonia~~  
interstitial pneumonitis hrs.

(b) Due To

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? None

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Robert Bornstein, M.D.

(Print or Type Name)

(Address) 180 Pleasant St. Date 7/18/64

Winthrop

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 21, 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP, MASS

Received and filed JUL 20 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)  
MALE WHITE MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN SINGLE

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years 1 Months 15 Days If under 24 hours  
Hours Minutes

13 Usual Occupation NONE  
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City) BOSTON  
(State or country) MASS

17 NAME OF FATHER DONALD P. CARR

18 BIRTHPLACE OF FATHER (City) EVERETT  
(State or country) MASS

19 MAIDEN NAME OF MOTHER SHIRLEY (KEENAN)

20 BIRTHPLACE OF MOTHER (City) BOSTON  
(State or country) MASS

21 Informant DONALD P. CARR

(Address) 70 COTTAGE PARK RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Surinann (3)  
(Signature of Agent of Board of Health or other)

Health Officer July 20, 1964  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

# RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

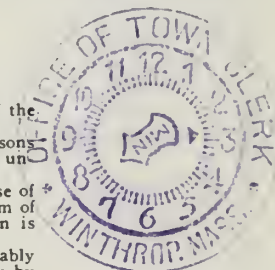
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED.



JUL 20 1964 PM

for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
use, or compli-  
which caused

ions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

itions contrib-  
death but not  
o the terminal  
condition given

M.C.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 129

Suffolk  
(County)

Winthrop  
(City or Town)

No. Bay View Nursing Home (If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME Ellen Oliver Duncan  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence, No. 52 Lowell Road St.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 months 10 days. In place of residence 46 years 6 months 10 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 21 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Feb. 1, 1964, to July 21, 1964.

I last saw him alive on July 19, 1964, death is said to  
have occurred on the date stated above, at 5 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL HEART DISEASE 5 MO

Due To (b) BRONCHO-PNEUMONIA 7 days

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS Senility

Was autopsy performed? no  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Signature) Louis F. Salerno, M. D.

LOUISE SALERNO  
(Print or Type Name)

(Address) WINTHROP MASS Date July 21, 1964

6 WINTHROP CEMETERY, WINTHROP, MASS.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 21, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUL 24 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Justin Alexander Duncan  
(Husband's name in full)

12 AGE 84 Years 6 Months 14 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: housewife  
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No.

16 BIRTHPLACE (City) Rouses Point  
(State or country) New York

17 NAME OF FATHER unable to obtain

18 BIRTHPLACE OF FATHER (City) New York  
(State or country)

19 MAIDEN NAME OF MOTHER unable to obtain  
Bridget Oliver

20 BIRTHPLACE OF MOTHER (City) New York  
(State or country)

21 Informant Frederic B. Duncan  
(Address)

45 Emerson Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
Mass. was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sciamm (P)  
(Signature of Agent of Board of Health or other)

Health Officer July 23, 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

RECEIVED



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
DEATH CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
more than one  
cause for each  
(a), (b) and (c)

does not mean  
mode of dying,  
heart failure,  
etc. It means  
cause, or compli-  
cation which caused

conditions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

conditions contrib-  
uted to death but not  
to the terminal  
condition given

PLACE OF DEATH

SUFFOLK  
(County)  
INTROPO  
(City or Town)



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 130

No. INTROPO COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ARTHUR J. MURRAY  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence No. 6 STATE ROAD St. REVERE  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 5 days. In place of residence 7 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 24 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
July 19, 1964, to July 24, 1964

I last saw him alive on July 24, 1964, death is said to  
have occurred on the date stated above, at 4:25 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

(b) Coronary arteriosclerosis

(c)

OTHER SIGNIFICANT CONDITIONS Obstructing duodenal ulcer

Was autopsy performed? NO

What test confirmed diagnosis? ECG

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) H. B. Greenfield, M. D.

447 St. Winthrop (Print or Type Name)

(Address) Winthrop, Mass. Date July 21, 1964

6 Holy Cross Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27, 1964

7 NAME OF FUNERAL DIRECTOR Frederick J Magrath

ADDRESS 325 Chelsea St. E, Boston

Received and filed JUL 27 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of Margaret G Gifford  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 50 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Bartender  
(Kind of work done during most working life)

14 Industry or Business: Buddy's Cafe

15 Social Security No. 017-14-7548

16 BIRTHPLACE (City) E, Boston  
(State or country)

17 NAME OF FATHER John J Murray

18 BIRTHPLACE OF FATHER (City) England  
(State or country)

19 MAIDEN NAME OF MOTHER Anna Quinn

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country)

21 Informant Mrs. Margaret G Murray  
(Address) 6 State Rd. Revere

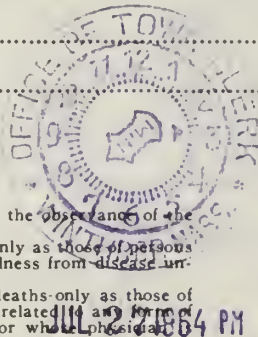
I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Seaman (Signature of Agent of Board of Health or other)

Health Officer July 25 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

RECEIVED



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to a form of injury, have died without recent medical attendance or whose physician was absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
than one  
e for each  
(b) and (c)

does not mean  
de of dying,  
heart failure,  
etc. It means  
ise, or compli-  
which caused

ions, if any,  
gave rise to  
cause (a),  
the under-  
cause last.

ditions contrib-  
death but not  
to the terminal  
condition given

PLACE OF DEATH

**Suffolk**  
(County)  
**Winthrop**  
(City or Town)

**Winthrop Community Hospital**

2 FULL NAME **Charles Richardson**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. **796 Saratoga St**  
(Usual place of abode)

**East Boston**

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months **10** days. In place of residence. **25** years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **7** **28** **1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Feb. 3,** 19 **64** to **7/28/** 19 **64**

I last saw him live on **7/28/** 19 **64** death is said to  
have occurred on the date stated above, at **8:35A.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Carcinoma of Cecum**  
Due To **with generalized metastases**  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS **None**

Was autopsy performed? **No**

What test confirmed diagnosis? **Pathological Specimen**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify

(Signature) **John F. Pepi**, M. D.

**John F. Pepi, M.D.**  
(Print or Type Name)

(Address) **821 Saratoga St.** Date **7/28/** 19 **64**

**E. Boston, Mass.**

**Woodlawn Cemetery, Everett**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 31st** 19 **64**

7 NAME OF FUNERAL DIRECTOR **Richard C. Kirby, Inc.**

ADDRESS **917 Bennington St., E. Boston**

Received and filed **JUL 28 1964** 19

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. **100**

**131**

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **No**

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **M** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED** **Married**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced,  
HUSBAND of **Hazel M. Hawes**  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE **71** Years **10** Months **18** Days If under 24 hours  
.....Hours.....Minutes

13 Usual Occupation: **Shipper**  
(Kind of work done during most working life)

14 Industry or Business: **Wholesale Fish**

15 Social Security No. **028-01-9423**

16 BIRTHPLACE (City) **Halifax**  
(State or country) **Nova Scotia**

17 NAME OF FATHER **Albert Richardson**

18 BIRTHPLACE OF FATHER (City) **Canada**  
(State or country)

19 MAIDEN NAME OF MOTHER **Roebena Cleveland**

20 BIRTHPLACE OF MOTHER (City) **Canada**  
(State or country)

21 Informant **Mrs. Hazel M. Richardson-wife**  
(Address) **796 Saratoga Street,**  
**East Boston, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Sirianni (M.D.)**  
(Signature of Agent of Board of Health or other)

(Official Designation)

**7-28-64**  
(Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
AL CERTIFICATE

OR TYPE  
OR CAUSES  
DEATH

not enter  
re than one  
se for each  
, (b) and (c)

does not mean  
ode of dying,  
s heart failure,  
t, etc. It means  
case, or compli-  
which caused

itions, if any,  
gave rise to  
cause (a),  
g the under-  
cause lost.

ditions contrib-  
o death but not  
to the terminal  
condition given

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

No. 66 Winthrop Shore Drive

Crest Haven Rest Home

2 FULL NAME

Annie Oesterburg (Shuber)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

41 Glendale St., Revere, Mass.

(a) Residence. No.

(Usual place of abode)

Length of stay: In place of death 3 years 5 months days. In place of residence 14 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATHJuly 29 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from

April 1, 1962 to July 29, 1964

I last saw him alive on July 29, 1964, death is said to

have occurred on the date stated above, at 12:45 PM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease

Due To

(b) arteriosclerosis

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature)

M. D.

(Address)

6 Winthrop

Place of Burial or Cremation

Winthrop

(City or Town)

DATE OF BURIAL

July 31

1964

7 NAME OF

FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass

Received and filed

JUL 30 1964

19

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

132

(If death occurred in a hospital or institution,  
St. (Give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(City or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Frederick Oesterburg

(Husband's name in full)

12

AGE

87

Years

7

Months

4

Days

If under 24 hours

Hours

Minutes

13

Usual

Occupation:

None

(Kind of work done during most of working life)

14

Industry

or Business:

At home

15

Social Security No.

None

16

BIRTHPLACE (City)

(State or country)

Austria

17

NAME OF

FATHER

John Shuber

18

BIRTHPLACE OF

FATHER (City)

(State or country)

Austria

19

MAIDEN NAME

OF MOTHER

Mary

20

BIRTHPLACE OF

MOTHER (City)

(State or country)

Austria

21

Informant

Old Age Assistance records

(Address)

Revere, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Scramm (S)

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED



JUL 30 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



FORM R-301

PLACE OF DEATH

SUFFOLK  
(County)BOSTON  
(City or Town)KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 05029

led for burial permit  
Board of Health  
or its Agent.INSTRUCTIONS  
FOR  
LEGAL CERTIFICATEINT OR TYPE  
SE OR CAUSES  
OF DEATHdo not enter  
more than one  
cause for each  
(a), (b) and (c)this does not mean  
mode of dying,  
as heart failure,  
pneumonia, etc. It means  
disease, or complica-  
tions which caused  
death.Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.Conditions contrib-  
uting to death but not  
leading to the terminal  
condition given  
(a).informal - wives  
- children  
8/1  
70x

No. Beth Israel Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 2 FULL NAME William Brenner (If deceased is a married, widowed or divorced woman, give also maiden name.)  
33 Myrtle Avenue St. Winthrop (City or town and State)  
 (a) Residence, No. (Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 22 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 22, 1964 to May 22, 1964  
 I last saw him alive on May 22, 1964, death is said to have occurred on the date stated above, at 2:45 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCTIONINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
24 hrs.Due To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?  
 What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
 If so, specify

(Signature) Paul Pote, M. D.

(Address) 320 Broadway Date May 22, 1964  
 (Print or Type Name)

6 Tifereth Israel of Winthrop Everett  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL MAY 24 19647 NAME OF FUNERAL DIRECTOR TORF Funeral Service Inc.ADDRESS WASHINGTON Ave ChelseaReceived and filed May 27 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word)  
 MARRIED  
 WIDOWED MARRIED  
 DIVORCED  
 UNKNOWN

11 If married, widowed, or divorced  
 HUSBAND of FRANCES KAUFMAN  
 (Give maiden name of wife in full)  
 (or) WIFE of (Husband's name in full)

12 63 Years. Months. Days If under 24 hours  
 AGE Hours. Minutes

13 Usual Occupation: MEAT CUTTER  
 (Kind of work done during most of working life)

14 Industry or Business: PROVISIONS

15 Social Security No. 012-26-208916 BIRTHPLACE (City) Russia  
(State or country)17 NAME OF FATHER ABRAHAM BRENNER

18 BIRTHPLACE OF FATHER (City) Russia  
 (State or country)

19 MAIDEN NAME OF MOTHER (EBC)

20 BIRTHPLACE OF MOTHER (City) Russia  
 (State or country)

21 Informant Mrs. FRANCES BRENNER  
 (Address) 33 Myrtle Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTACHED

*William J. Kane.*  
City Registrar

RECEIVED



AUG 11 1964 AM

FORM R-301

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)


 KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 05408

 filed for burial permit  
 by Board of Health  
 or its Agent.

 INSTRUCTIONS  
 FOR  
 MEDICAL CERTIFICATE

No. BOSTON CITY HOSPITAL

 (If death occurred in a hospital or institution,  
 St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

 2 FULL NAME **Emory Frank Fraser** **Frank E Fraser**  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a  
 U. S. War Veteran,  
 if so specify WAR) **W.W.1**

 63 ~~107~~ Waldemar Ave.  
 (a) Permanent Residence. No.  
 (Usual place of abode)

Winthrop, Mass.

(City or town and State)

 INT OR TYPE  
 SE OR CAUSES  
 OF DEATH

 do not enter  
 more than one  
 cause for each  
 (a), (b) and (c)

 is does not mean  
 mode of dying,  
 as heart failure,  
 pneumonia, etc. It means  
 disease, or compli-  
 cations which caused  
 death.

 Conditions contrib-  
 uted to death but not  
 related to the terminal  
 disease condition given  
 (a), (b) and (c).

Length of stay: In place of death.....years.....months.....3 days. In place of residence 40 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH **May 27 1964**  
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That ~~the deceased~~ **was a patient**  
**May 25, 1964**, to **May 27, 1964**

 I last saw him/her on **May 27, 1964**, death is said to  
 have occurred on the date stated above, at **5:42 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

**Intercerebral and Subarachnoid**(a) **Hemorrhage** **2 Days**(b) **Hypertensive vascular disease**(c) **With Hypertensive Heart Disease**
 OTHER SIGNIFICANT  
 CONDITIONS **Diabetes Mellitus**

Was autopsy performed?

What test confirmed diagnosis?

 5 Was disease or injury in any way related to occupation of deceased?  
 If so, specify

 (Signature) **M. WINTHROP O'CONNELL, M.D.**  
 (Print or Type Name)

 BOSTON CITY HOSPITAL Date **5-28-64**

 6 **Winthrop Cemetery, Winthrop, Mass.**  
 Place of Burial or Cremation (City or Town)
DATE OF BURIAL **June 1, 1964**
 7 NAME OF FUNERAL DIRECTOR **Arthur B. Marsh**
ADDRESS **174 Winthrop St., Winthrop**Received and filed **JUN 4 1964**
 (Signature of Registrar) **William J. Kane**  
 (Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

 8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)  
**married**  
 11 If married, widowed, or divorced  
 HUSBAND of **Edith Lillian Hanson**  
 (Give maiden name of wife in full)  
 (or) WIFE of (Husband's name in full)

 12 AGE **66** Years **10** Months **26** Days  
 If under 24 hours  
 Hours Minutes

 13 Usual Occupation **retired fireman**  
 (Kind of work done during most of working life)

 14 Industry or Business **Boston Fire Dept.**
15 Social Security No. **031-01-1157**
 16 BIRTHPLACE (City) **East Boston**  
 (State or country) **Massachusetts**

 17 NAME OF FATHER **William Warren Fraser**

 18 BIRTHPLACE OF FATHER (City) **Boston**  
 (State or country) **Massachusetts**

 19 MAIDEN NAME OF MOTHER **Alice E. Emory**

 20 BIRTHPLACE OF MOTHER (City) **Boston**  
 (State or country) **Massachusetts**

 21 Informant **Mrs. Frank E. Fraser**  
 (Address) **63 Waldemar Ave., Winthrop**

 I HEREBY CERTIFY that a satisfactory standard certificate of death  
 was filed with me BEFORE the burial or transit permit was issued:

 (Signature of Agent of Board of Health or other) **Leo J. Cogswell**

(Official Designation)

(Date of Issue of Permit) **6/1/64**



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



AUG 11 1964 AM

FORM R-301

ed for burial permit  
Board of Health  
r its Agent.

STRUCTIONS  
FOR  
AL CERTIFICATE

NT OR TYPE  
E OR CAUSES  
F DEATH

o not enter  
ore than one  
use for each  
a), (b) and (c)

s does not mean  
mode of dying,  
as heart failure,  
ia, etc. It means  
cause, or compli-  
which caused

ditions, if any,  
ch gave rise to  
ve cause (a),  
ing the under-  
g cause last.

onditions contrib-  
to death but not  
to the terminal  
condition given

Medical  
Examiner  
Declined  
Jurisdiction

AUG 11 1964  
9-63-936348

OUT OF TOWN

Suffolk

(County)

Boston

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

Registered No. 05324

No. Veterans Administration Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John W. MERCHANT Sr.  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, WWI  
if so specify WAR)

(a) Permanent Residence. No. 4 Revere  
(Usual place of abode)

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months -1 days. In place of residence years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 29 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
May 29 1964 to May 29 1964

death is said to  
have occurred on the date stated above, at 1:10 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Probable acute coronary occlusion 2 Hrs

Due To Arteriosclerotic heart disease 15 Yrs

(b) Due To

(c) OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Albert L. Gooty M. D.

(Address) VAN, Boston, Mass. 5-29- 1964

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 1 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

147 Winthrop St

ADDRESS Winthrop, Mass.

Received and filed JUN 3 1964

William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED Married  
DIVORCED  
UNKNOWN

11 If married, widowed or divorced  
HUSBAND of Gladys Doane  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 65 Years 7 Months 13 Days If under 24 hours  
Hours Minutes

13 Usual Occupation Machinist (Retired)  
(Kind of work done during most of working life)

14 Industry or Business C.N.B.

15 Social Security No. 023 09 6011

16 BIRTHPLACE (City) Gloucester  
(State or country) Mass.

17 NAME OF FATHER Everett Merchant

18 BIRTHPLACE OF FATHER (City) Gloucester  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Sarah Harris

20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country) Canada

21 Informant V.A. Hospital Records  
150 S. Huntington Ave.  
(Address) Boston 30, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Norma Mac Doane  
(Signature of Agent of Board of Health or other)

22162 5/29/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



AUG 11 1964 AM



FORM R-301

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
 CERTIFICATE OF DEATH

Registered No. 05591

PLACE OF DEATH

SUFFOLK

(County)

ROXBURY

(City or Town)

No. Jewish Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

TENA SHUTZMAN

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No.

236 Shore Drive WINTHROP

(Usual place of abode)

(City or town and State)

Length of stay: In place of death 1 years 2 months 28 days. In place of residence 4 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

June 6 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH 4, 1963, to JUNE 6, 1964.

I last saw her alive on JUNE 6, 1964 death is said to have occurred on the date stated above, at 4:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

minutes

Due To

(b)

ASHD

YEARS

Due To

(c)

CVA Left hemiparesis &amp; some mild speech trouble

OTHER SIGNIFICANT CONDITIONS

DIABETES MELLITUS 20 YEARS

Was autopsy performed?

NO

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature)

René Bernard

M. D.

(Print or Type Name)

(Address) Jewish Memorial Hospital June 6, 1964

6

Vilno

West Roxbury

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

June 7

1964

7 NAME OF FUNERAL DIRECTOR

Philip Briss

ADDRESS 304 Washington St., Dorchester

Received and filed

JUN 10 1964

19

William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

male

white

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Ralph Shutzman

(Husband's name in full)

12

AGE 72 years Months Days

If under 24 hours

Hours Minutes

13 Usual

Occupation

Housewife

(Kind of work done during most of working life)

14 Industry or Business

at home

15 Social Security No.

not known

16 BIRTHPLACE (City)

New York N.Y.

(State or country)

17 NAME OF FATHER

Joseph Goodman

18 BIRTHPLACE OF FATHER (City)

Russia

(State or country)

19 MAIDEN NAME OF MOTHER

Fannie Marcus

20 BIRTHPLACE OF MOTHER (City)

Russia

(State or country)

21 Informant

Mrs. Irene Robertson

(Address)

20 Somner St., Canton, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

J. B. Kane

(Official Designation)

June 7, 1964

(Date of Issue of Permit)

A TRUE COPY

2-62-934553

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



AUG 27 1964 AM

d for burial permit  
Board of Health  
its Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

TOR TYPE  
OR CAUSES  
DEATH

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to the terminal  
condition given

1964

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

137

(City or Town making this return)

05721

Registered No.

PLACE OF DEATH

Suffolk

(County)

Boston

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

No. DON ORIONE NURSING HOME

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph Mancuso

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 45 Waldemar Avenue

(Usual place of abode)

Since December 11, 1963

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 8, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from  
Dec. 11, 1963 to June 5, 1964I last saw him live on June 5, 1964 death is said to  
have occurred on the date stated above, at 4:00 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Dis.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 da.

(b) General arteriosclerosis

yrs.

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Charles Meloni M.D.  
Dr. Charles Meloni, M.D.

(Address) 45 Bayswater St., E.B. 6/8/1964

6 Winthrop Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 11 1964

7 NAME OF FUNERAL DIRECTOR Ernest Paggiano

ADDRESS 147 Winthrop St Winthrop Mass

Received and filed JUN 12 1964 JUN 12 1964

William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN WIDOWED

11 If married, widowed, or divorced  
HUSBAND of Lydia Mancuso (DeGiacomo)  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 79 Years 10 Months 9 Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Barber  
(Kind of work done during most working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City) Italy  
(State or country)

17 NAME OF FATHER SALVATORE MANCUSO

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Grace Rinaldi

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)21 Informant Edith E Violotte  
(Address) 45 Waldemar Ave Winthrop MassI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Geo J. Coagswell  
(Signature of Agent of Board of Health or other)22319 June 9, 1964  
(Official Designation) (Date of Issue of Permit)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



AUG 27 1964 AM

FORM R-301

for burial permit  
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G 27 1964

62-934553

The Commonwealth of Massachusetts

OUT OF TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

MASSACHUSETTS GENERAL HOSPITAL

No.



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

138

STANDARD

CERTIFICATE OF DEATH

Registered No. 05977

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Joseph B. Bergman  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence. No. 56 Floyd St.  
(Usual place of abode)

St. Winthrop, Mass.  
(City or town and State)

Length of stay: In place of death years months 3 days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
June 13 64 to June 15 64  
I last saw him alive on June 15 1964 death at 4:25 a.m.

have occurred on the date stated above, at 4:25 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PULMONARY EDEMA, MODERATE

Due To (b) HEMORRHAGE ACUTE LEFT

(c) CEREBRAL HEMISPHERE

OTHER SIGNIFICANT CONDITIONS HYPERTENSIVE HEART DISEASE

Was autopsy performed? Yes.

What test confirmed diagnosis? Autopsy.

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles L. Clay, M.D., M. D.

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date June 15 1964

6 Forest Hills Cemetery, Jamaica Plain  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 17, 1964

7 NAME OF FUNERAL DIRECTOR A. L. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed JUN 19 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Margaret Fuller  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE 84 Years 5 Months 11 Days If under 24 hours  
Hours Minutes

13 Usual Occupation retired Sea Captain  
(Kind of work done during most of working life)

14 Industry or Business Narrow Gage Ferries

15 Social Security No. 021-14-1110

16 BIRTHPLACE (City) Sweden  
(State or country)

17 NAME OF FATHER Nils Bergman

18 BIRTHPLACE OF FATHER (City) Sweden  
(State or country)

19 MAIDEN NAME OF MOTHER unknown

20 BIRTHPLACE OF MOTHER (City) Duluth  
(State or country) minnesota

21 Informant Joseph Russell Bergman

(Address) 56 Floyd St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
has been filed with me BEFORE the burial or transit permit was issued:  
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY APR 1964

*William J. Kane.*  
City Registrar

RECEIVED



AUG 27 1964 AM



RM R-301

For burial permit  
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Agent.

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OUT - OF - TOWN  
SUFFOLK  
(County)  
BOSTON  
(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

139

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 06131

No. BETH ISRAEL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FRANCES BRENNER  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 33 MYRTLE AVE, WINTHROP St. WINTHROP, MASS.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death years months 3 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 21 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from JUNE 18 1964 to JUNE 21 1964

I last saw him alive on JUNE 21 1964 death is said to have occurred on the date stated above, at 110 A. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia bilateral

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS acute bact. endocarditis, mitral valve

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Neil R. Blacklow M. D.  
NEIL R. BLACKLOW  
(Print or Type Name)

(Address) 330 BROOKLINE AVE. Date JUNE 21 1964

6 Place of Burial or Cremation 25 Bradford Street Wintthrop  
(City or Town)

DATE OF BURIAL JUNE 22 1964

7 NAME OF FUNERAL DIRECTOR Bay State Funeral Home  
F. H. H. H.

ADDRESS

Received and filed JUN 25 1964  
W. J. Williams (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) William A. Brennan (or) WIFE of (Husband's name in full)

12 AGE 41 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business Robert's Home

15 Social Security No. 72-000000000

16 BIRTHPLACE (City) (State or country) New York

17 NAME OF FATHER Harry Kaufman

18 BIRTHPLACE OF FATHER (City) (State or country) New York

19 MAIDEN NAME OF MOTHER C. B. Z.

20 BIRTHPLACE OF MOTHER (City) (State or country) New York

21 Informant June Fialkoff (Address) 25 Bradford Street Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

22461 June 22 1964 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*

City Registrar

RECEIVED



SEP 3 1964 AM

OUT - OF - TOWN



The Commonwealth of Massachusetts  
EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

To be filed for burial  
permit with Board of  
Health or its Agent.

Registered No. 06241

PLACE OF DEATH

Suffolk  
(County)

Boston  
(City or Town)

No. 818 Harrison Avenue

St.

Ward

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME.

Morris Greenblatt

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

NO

(a) Residence. No. 55 Jave Jay Ave.  
(Usual place of abode)

St.

Ward

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

days.

How long in U. S., if of foreign birth?

yrs.

mos.

days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR

5 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED

Male

White

5a If married, widowed, or divorced.

HUSBAND of

Ruth Margil  
(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

6 Age of husband or wife if alive

years

7 IF STILLBORN, enter that fact here.

8

AGE 67 Years Months Days

If less than 1 day

Hours Minutes

Usual

9 Occupation:

Garment Cutter

10 Industry  
or Business:

Garment

11 Social Security No.

12 BIRTHPLACE (City)  
(State or country)

Vilnor Poland

13 NAME OF  
FATHER

Hyman Greenblatt

14 BIRTHPLACE OF  
FATHER (City)  
(State or country)

Poland

15 MAIDEN NAME  
OF MOTHER

Shainert Portchvick

16 BIRTHPLACE OF  
MOTHER (City)  
(State or country)

Poland

17

Informant Mrs. Ruth Greenblatt (wife)  
(Address) 55 Jave Jay Ave., Winthrop

Relation, if any

HEREBY CERTIFY that a satisfactory standard certificate of death was  
filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF  
DEATH

June 24 1964  
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person  
above-named and that the CAUSE AND MANNER thereof are as follows:  
(If an injury was involved, state fully.)

Hypertensive  
Heart  
Disease

20 IN WHAT CITY OR TOWN  
WAS INJURY SUSTAINED?

(Signed)

784 Mass. Avenue Date 6-24-64

21 PLACE OF BURIAL.  
CREMATION OR REMOVAL

Winthrop  
Cemetery (City or town)

DATE OF BURIAL

June 25 1964

22 NAME OF  
UNDERTAKER

Morris Breznick

ADDRESS 470 Harvard St., Brookline

Received and filed

JUN 29 1964

19

(Registrar)



A TRUE COPY ATTEST:

RECEIVED

*William J. Kr...*

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SEP 3 1964 AM

burial permit  
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Agent.

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3-1964

OUT - OF - TOWN

Suffolk

(County)

Boston

(City or Town)

No. Veterans Administration Hospital

2 FULL NAME

ANNE G. ADAMS

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

209 River Road

(Usual place of abode)

xx Winthrop, Mass.

(City or town and State)

Length of stay: In place of death... years 4 months 7 days. In place of residence 45 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 25 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That VA attended deceased from February 18, 64 to June 25, 64

death is said to have occurred on the date stated above, at 9:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia, bilateral

(b) Due To Metastatic carcinoma of breast to bone with patho-

(c) Due To logical fracture

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Hugh F. McCarthy, M. D.  
Hugh F. McCarthy  
(Print or Type Name)

(Address) VAH, Boston, Mass. Date June 26, 1964

6 Winthrop Cem., Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 29 1964

7 NAME OF FUNERAL DIRECTOR O'Malley Funeral Home

ADDRESS 79 Atlantic St. Winthrop, Mass.

Received and filed JUN 30 1964

William J. Seavey

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 06308

{(If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN - IMPORTANT

{(Was deceased a U. S. War Veteran, WWI if so specify WAR)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George J. Adams  
(Husband's name in full)

12 AGE 66 Years 9 Months 6 Days

If under 24 hours  
Hours Minutes

13 Usual Occupation Housewife

(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER Bernard Adams Brogan

18 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Catherine J. McLaughlin

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.21 Informant VA Hospital Records, 150 So.  
Huntington Ave., Boston, Mass.

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Beller 00343  
(Signature of Agent of Board of Health or other)June 28, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY. ATTEST:

RECEIVED

*William J. Kane*

City



SEP 3 1964 AM



burial permit  
of Health  
Agent.

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OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

CHILDREN'S HOSPITAL MEDICAL CENTER

No.

DOUGLAS EDWARD BOWLES

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

93 COURT ROAD

(a) Residence, No.  
(Usual place of abode)

23 HOURS

WINTHROP, MASS.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE 26 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
June 25 1964 to June 26 1964I last saw him alive on June 26 1964 death is said to  
have occurred on the date stated above, at 9:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) RESPIRATORY ARREST

Due To IDIOPATHIC RESP DISEASE

(b) SYNDROME

OTHER  
SIGNIFICANT  
CONDITIONS

prematurity

Was autopsy performed?

What test confirmed diagnosis? clinical findings + x-ray

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) John D. Green, M. D.

JOHN D. GREEN, M.D.

(Address) 300 Longwood Ave, Date June 26 1964

6 Winthrop Cemetery

Place of Burial or Crenation (City or Town)

DATE OF BURIAL June 29 1964

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS 210 Wintthrop St. Wintthrop

Received and filed William J. Kane, 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

Registered No. 06298

(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Male white single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE.....Years.....Months.....Days 13 If under 24 hours  
None 23 Hours.....Minutes14 Usual Occupation None  
(Kind of work done during most of working life)15 Industry  
or Business

16 Social Security No. None

17 BIRTHPLACE (City)  
(State or country) Boston

18 NAME OF FATHER Roy A. Bowles

19 BIRTHPLACE OF FATHER (City)  
(State or country) Winthrop

20 MAIDEN NAME OF MOTHER Edith Barker

21 BIRTHPLACE OF MOTHER (City)  
(State or country) Winthrop

22 Informant Roy A. Bowles

(Address) 93 Court Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:F. Shaca C.00333  
(Signature of Agent of Board of Health or other)(Official Designation) June 28, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane* RECEIVED  
City Registrar



SEP 3 1964 AM

M R-301

burial permit  
of Health  
Agent.

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3-1964

Director  
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1934553

OUT - OF - TOWN  
SUFFOLK

PLACE OF DEATH

BOSTON

(County)

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 06487

{If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)  
PHYSICIAN - IMPORTANT2 FULL NAME Alice Rita Moran  
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a  
U. S. War Veteran,  
if so specify WAR) N.O.(a) Residence. No. 41 Hillside Ave.  
(Usual place of abode)St. Winthrop, Mass.  
(City or town and State)

Length of stay: In place of death.....years.....months.....3 days. In place of residence 35 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 1 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
June 29 1964 to July 1 1964

I last saw her live on July 1 1964 death is said to

have occurred on the date stated above, at 5:00 a. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive Heart Failure with  
acute pulmonary edema.(b) Rheumatic Heart Disease &  
mitral stenosis.

(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

1 mo.

45 Yrs.

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No.

What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date July 1 1964

6 WINTHRIP WINTHRIP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JULY 3 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. HIRBY

ADDRESS 211 WINTHRIP ST WINTHRIP

Received and filed JUL 7 1964

William J. Haver

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN SINGLE

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 49 Years.....Months.....Days If under 24 hours  
Hours.....Minutes13 Usual Occupation RESTAURANT WORKER  
(Kind of work done during most of working life)

14 Industry or Business RESTAURANT

15 Social Security No. NONE

16 BIRTHPLACE (City) EAST BOSTON  
(State or country) MASS

17 NAME OF FATHER DANIAL A MORAN

18 BIRTHPLACE OF FATHER (City) BOSTON  
(State or country) MASS

19 MAIDEN NAME OF MOTHER MARY E PITTS

20 BIRTHPLACE OF MOTHER (City) EAST BOSTON  
(State or country) MASS21 Informant MRS MARY MORAN  
(Address) 41 HILLSIDE AVE WINTHRIPI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transfer permit was issued:  
Donald E. D. Hoxenberry  
(Signature of Agent of Board of Health or other)35023 July 2, 1964  
(Official Designation) (Date of Issue of Permit)



RECEIVED



SEP 3 1964 AM

AM R-302

PLACE OF DEATH

Suffolk

(County)

Chelsea

(City or Town)


 KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

Chelsea

(City or Town making this return)

 COPY OF  
 CERTIFICATE OF DEATH

Registered No. 406

No. 17 Lafayette Ave.

(If death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)
 2 FULL NAME Lea Ostrowitz  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a  
 U. S. War Veteran,  
 if so specify WAR)

 (a) Residence. No. 252 Shirley  
 (Usual place of abode)

 St. Winthrop, Mass.  
 (City or town and State)

Length of stay: In place of death. years. months. days. In place of residence. years. months. days.

## MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH July 31, 1964  
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY That I attended deceased from  
 Mar. 1964 to July 31 1964  
 I last saw her on July 30 1964 death is said to  
 have occurred on the date stated above, at 2:30A.

 INTERVAL  
 BETWEEN  
 ONSET AND  
 DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral thrombosis 6mos.

 Due To  
 (b) Cardio-vascular disease ?

 Due To  
 (c)

 OTHER  
 SIGNIFICANT  
 CONDITIONS Parkinson's disease ?

 Was autopsy performed? no  
 What test confirmed diagnosis? clinical signs

 5 Was disease or injury in any way related to occupation of deceased?  
 If so, specify

(Signature) M.J. Greenfield, M. D.

(Address) Chelsea, Mass. 7/31/64

 6 Workmen Circle, W. Roxbury, Mass.  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 31, 1964

7 NAME OF FUNERAL DIRECTOR Benjamin Bernbach

ADDRESS 10 Washington St. Dorchester

Received and filed 19.

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

 8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
 MARRIED  
 WIDOWED  
 DIVORCED  
 UNKNOWN Widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

 (or) WIFE of Isaac Ostrowitz  
 (Husband's name in full)

 12 AGE 91 Years. Months. Days If under 24 hours  
 Hours. Minutes

 13 Usual Occupation: Housewife  
 (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

 16 BIRTHPLACE (City) Austria  
 (State or country)

17 NAME OF FATHER Leiser Gold

 18 BIRTHPLACE OF FATHER (City) Austria  
 (State or country)

19 MAIDEN NAME OF MOTHER Anna (cannot be learned)

 20 BIRTHPLACE OF MOTHER (City) Austria  
 (State or country)

21 Informant Stanetsky Chapel

(Address) 10 Washington St., Dor. Mass.

A TRUE COPY

 ATTEST: Joseph A. Tyrrell  
 (Registrar of City or Town where death occurred)

DATE FILED July 31, 1964

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



PLACE OF DEATH

1

SUFFOLK  
(County)WINTHROP  
(City or Town)

## The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHTo be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

145

No. BAY VIEW NURSING HOME St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)2 FULL NAME GUSSIE STARR  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 31 GREEN PK. St. NEWTON  
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death 8 years 8 months 7 days. In place of residence 7 years 7 months 7 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 2 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
October 1963 to August 2, 1964  
I last saw he/she alive on August 2, 1964, death is said tohave occurred on the date stated above, at 12:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of UterusINTERVAL  
BETWEEN  
ONSET AND  
DEATH8 mosDue To  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONSGeneralized Arteriosclerosis 2 yrsWas autopsy performed? NoWhat test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signed) Charles Liberman, M. D.(Address) WINTHROP, MASS Date 8/2/19646 TRIDE OF LYNN LYNN  
Place of Burial or Cremation (City or Town)DATE OF BURIAL AUG. 3, 1964 197 NAME OF FUNERAL DIRECTOR Louis HymanADDRESS LynnReceived and filed AUG 3 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
OR DIVORCED10a If married, widowed, or divorced  
HUSBAND of(Give maiden name of wife in full)  
(or) WIFE of WALTER STARR  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 0 Months 4 Days If under 24 hours  
Hours      Minutes     13 Usual Occupation: HOUSEWIFE  
(Kind of work done during most of working life)14 Industry or Business: AT HOME15 Social Security No. NONE16 BIRTHPLACE (City) AUSTRIA  
(State or country)17 NAME OF FATHER MORRIS SUGARMAN18 BIRTHPLACE OF FATHER (City) AUSTRIA  
(State or country)19 MAIDEN NAME OF MOTHER MARY - UNKNOWN20 BIRTHPLACE OF MOTHER (City) AUSTRIA  
(State or country)21 Informant EDITH MARLYN - DAUGHTER  
(Address) 69 ORCHARD RD SWANSCOTTI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Sirian (Signature of Agent of Board of Health or (other))Health Officer 8-3-64  
(Official Designation) (Date of Issue of Permit)

**EXTRACTS**  
**FROM THE LAWS OF THE**  
**COMMONWEALTH OF MASSACHUSETTS**  
**GOVERNING THE**  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and forty-two, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION**

**DATE OF ENTERING MILITARY SERVICE**

**DATE OF DISCHARGE**

**RANK, RATING**

**ORGANIZATION AND OUTFIT**

**SERVICE NUMBER**





for burial permit  
ard of Health  
ts Agent.

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CERTIFICATE

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop, Mass.  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **146**

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

BAY VIEW NURSING HOME

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Thomas Davidson**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **No**

(a) Residence, No. **32 Billows Street** St. **Winthrop, Mass.**  
(Usual place of abode) (City or town and State)

Length of stay: In place of death **10** months **50** years **50** months **50** days

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 6 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**July 20, 1963**, to **Aug 6, 1964**  
I last saw him alive on **August 4, 1964** death is said to  
have occurred on the date stated above, at **5:15 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Cerebral vascular accident**

Due To **Arteriosclerosis**

Due To  
(b)

OTHER  
SIGNIFICANT **uremia**  
CONDITIONS

Was autopsy performed? **No**

What test confirmed diagnosis? **—**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify **—**

(Signature) **H. B. Greenfield** M. D.

**H. B. Greenfield**  
(Print or Type Name)

(Address) **447 Summer St. Boston** Date **Aug 6 1964**

6 **Woodlawn Crematory** **Everett**  
Place of Burial or Cremation (City or Town) **Mass.**

DATE OF BURIAL **August 8** 19**64**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop**

Received and filed **AUG 7 1964** 19**64**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED** **single**  
**UNKNOWN**

11 If married, widowed, or divorced  
HUSBAND of **—**  
(Give maiden name of wife in full)

(or) WIFE of **—**  
(Husband's name in full)

12 AGE **83** Years **5** Months **8** Days If under 24 hours  
Hours Minutes

13 Usual Occupation **Ventilation Installer**  
(Kind of work done during most of working life)

14 Industry or Business **Air duct installation**

15 Social Security No. **023 10 7630**

16 BIRTHPLACE (City) **Dundee, Scotland**  
(State or country)

17 NAME OF FATHER **Andrew Davidson**

18 BIRTHPLACE OF FATHER (City) **Scotland U. K.**  
(State or country)

19 MAIDEN NAME OF MOTHER **Mary Stevens**

20 BIRTHPLACE OF MOTHER (City) **Scotland**  
(State or country) **United Kingdom**

21 Informant **Mrs. Helen Stevens**  
(Address) **529 Auburn St. Newton, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph B. Sericome (3)**

(Signature of Agent of Board of Health or other)

**Health Officer**  
(Official Designation)

**August 7, 1964**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

for burial permit  
ward of Health  
Agent.

INSTRUCTIONS  
FOR  
CERTIFICATE

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DEATH

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. 147

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 154 Court Road

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rose V. Femino (Calamoneri)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran, 110  
if so specify WAR)

(a) Residence. No. 154 Court Road  
(Usual place of abode)

St. Winthrop

(City or town and State)

Length of stay: In place of death. 2 years months days. In place of residence. 12 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 6, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from  
JAN 5 1957 19 to Aug 6 1964

I last saw him alive on Aug 6 1964, death is said to  
have occurred on the date stated above, at 12:30 AM.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY INFARCTION

Due To (b) ACUTE LEFT VENTRICULAR FAILURE 5 hrs

Due To

(c)

OTHER SIGNIFICANT CONDITIONS DIABETES MENITUS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Ernest P. Calamoneri, M. D.

(Address) 20 Saratoga St., B. 3/6, 64

6 Winthrop Cemetery, Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 8, 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Calamoneri

ADDRESS 147 Winthrop St., Winthrop

Received and filed AUG 11 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Bruno Femino (Husband's name in full)

12 AGE 79 Years 5 Months 2 Days If under 24 hours  
Hours Minutes

13 Usual Occupation housewife  
(Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No.

16 BIRTHPLACE (City) Messine (State or country) Italy

17 NAME OF FATHER Paul Calamoneri

18 BIRTHPLACE OF FATHER (City) Messine (State or country) Italy

19 MAIDEN NAME OF MOTHER Domenica Luccio

20 BIRTHPLACE OF MOTHER (City) Messine (State or country) Italy

21 Informant Males Maresco  
154 Court Rd., Winthrop  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph B. Linnane (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) Aug 6 1964 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

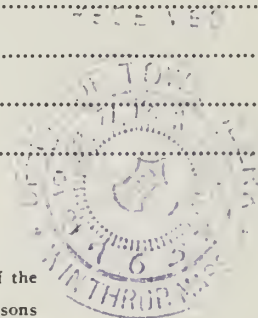
(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

---

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



AUG 11 1964 AM



For burial permit  
of Health  
Agent.

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CERTIFICATE

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death but not  
the terminal  
condition given

m. c.

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. 194 Herman



The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

Winthrop  
(City or Town making this return)

Registered No. 148

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Clara Fopiano  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No.

(a) Residence. No. 194 Herman St. Winthrop  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 38 years months days. In place of residence 38 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. 8 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Sept. 1953 to Aug. 8 1964

I last saw her alive on Aug. 7 1964, death is said to  
have occurred on the date stated above, at 10:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hodgkin's Disease

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

arteriosclerosis - gen

Was autopsy performed?

What test confirmed diagnosis? K. Ray

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph G. George, M. D.

Joseph G. George  
(Print or Type Name)

(Address) 194 Winthrop St. Date 8/10 1964

6 Old Calvary Boston  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 11, 1964

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed AUG 10 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Female White MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Single

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years 7 Months 1 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: At home  
(Kind of work done during most of working life)

14 Industry  
or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER Giovanni B. Fopiano

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Luisa Leverone

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Mrs. Rose Biggio  
(Address) 184 Herman St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Joseph B. George (Signature of Agent of Board of Health or other)

Health Officer Aug 18, 1964  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....



\_\_\_\_\_  
RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

\_\_\_\_\_  
**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

\_\_\_\_\_  
**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 NAME OF FETUS  
(if given)

Baby Boy Amalafitano

St. } (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

Registered No. 149

3 DATE OF  
DELIVERY8-9-64  
(Month) (Day) (Year)

4 SEX

Male ☒ Female ☐ Undetermined ☐5 COLOR (if  
determined) W6 THIS BIRTH (Check one)  
Single ☒ Twin ☐ Triplet ☐7 IF MULTIPLE BIRTH, BORN:  
1st 2nd 3rd8 FULL  
NAME

John Amalafitano

9 RESIDENCE, NO. 194  
CITY OR TOWN East Boston STATE Mass10 COLOR OR  
RACE W11 AGE AT TIME OF  
THIS DELIVERY 39 (Years)12 PLACE OF  
BIRTH Italy

(City or Town) (State or country)

13 OCCUPATION

Meat Cutter

14 MAIDEN NAME  
PRESENT NAMEAngela D. Alessandro  
Angela Amalafitano15 RESIDENCE, NO. 194  
CITY OR TOWN East Boston STATE Mass16 COLOR OR  
RACE W17 AGE AT TIME OF  
THIS DELIVERY 30 (Years)18 PLACE OF  
BIRTH Italy

(City or Town) (State or country)

19 INFORMANT

Angela Amalafitano

20 PREVIOUS DELIVERIES TO MOTHER  
(Do not include this fetus)

1

(a) How many children are  
now living?

1

(b) How many children were  
born alive but are now  
dead?(c) How many previous fetal  
deaths of ANY gestation  
age?21 LENGTH OF  
PREGNANCY 42  
completed weeks22 Weight Lb. 7 Oz. 1  
(or Grams)23 WHEN DID FETUS DIE?  
Before ☐ During Labor ☒ or Delivery ☐ Unknown ☐24 AUTOPSY  
Yes ☐ No ☐

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Gyphylia

Due To (b)

Cord around neck

Due To (c)

OTHER SIGNIFICANT  
CONDITIONS26 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG. 10, 1964

27 NAME OF  
FUNERAL DIRECTOR DIPIETRO VAZZA  
ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed

AUG 10 1964

19

(Registrar)

A TRUE COPY ATTEST:

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

(STILLBIRTH)

To be filed for burial permit with  
Board of Health or its Agent.In giving  
CAUSE OF  
FETAL DEATHdo not enter  
more than one  
use for each  
of (a), (b)  
and (c)l or maternal  
condition causing  
fetal death (do  
not use such  
as stillbirth  
prematurity.)l and/or mal-  
formation, which  
gave rise to above  
cause (a), stating  
underlying  
cause.ditions of fetus  
mother which  
have contrib-  
uted to fetal  
death, but, in so  
far as is known,  
are not related  
to cause given  
in (a).I HEREBY CERTIFY that this delivery occurred on the date stated  
above at 4:07 a.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:

Marion C. Sabia M.D.

MARION C. SABIA  
(PRINT OR TYPE NAME)Address 241 Monmouth St. Date 8/9 1964  
East BostonI HEREBY CERTIFY that a satisfactory certificate of fetal death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Siriani (G)  
(Signature of Agent of Board of Health or other)Death Officer Aug 10, 1964  
(Official Designation) (Date of Issue of Permit)



## FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48.  
ACTS OF 1960.

*Section 2A.* "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except . . .

*Section 9A.* When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

*Section 12.* ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

*Section 24.* In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

burial permit  
of Health  
Agent.

CERTIFICATE

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A.C.

Declined by Medical Examiner

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. 21 Townsend Avenue

## STANDARD CERTIFICATE OF DEATH

Registered No. 150

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)  
**PHYSICIAN — IMPORTANT**

2 FULL NAME Edith Hildegard Allen ( Erickson )  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Permanent Residence. No. 21 Townsend Avenue St. (City or town and State)  
(Usual place of abode)

Length of stay: In place of death 28 years months days. In place of residence 28 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 13 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19 to 19

I last saw h alive on 19, death is said to  
have occurred on the date stated above, at 10:15 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death-presumably due to  
(b) Due to natural causes. Patient  
had cholecystectomy done  
(c) about 12 days prior to demise

OTHER SIGNIFICANT CONDITIONS  
Winthrop Board of Health  
Charles Lieberman M.D.

Was autopsy performed?  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Lieberman, M. D.  
(Print or Type Name)  
(Address) WINTHROP, MASS Date 8/14/64

6 Winthrop Cemetery Winthrop, Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 15, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed AUG 14 1964

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)  
female white MARRIED married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of Robert Milne Hamilton Allen  
(Husband's name in full)

12 AGE 59 Years 11 Months 12 Days  
If under 24 hours  
Hours Minutes

13 Usual Occupation Insurance Underwriter  
(Kind of work done during most of working life)

14 Industry or Business General Insurance

15 Social Security No. 021-05-4352

16 BIRTHPLACE (City) Brockton  
(State or country) Massachusetts

17 NAME OF FATHER Emil Erickson

18 BIRTHPLACE OF FATHER (City) Sweden  
(State or country)

19 MAIDEN NAME OF MOTHER Louisa Ask

20 BIRTHPLACE OF MOTHER (City) Sweden  
(State or country)

21 Informant Robert M.H. Allen  
(Address) 21 Townsend Avenue

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (M.D.)  
(Signature of Agent of Board of Health or other)  
Health Officer 8/14/64  
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



For burial permit  
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s Agent.

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CERTIFICATE

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **151**

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. **Bay View Nursing Home**

(If death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Alma Gustafa Nelson (Anderson)**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO.**

(a) Residence. **249 Pleasant Street**  
(Usual place of abode)

St. **Winthrop, Mass.**  
(City or town and State)

Length of stay: In place of death **3** years **6** months **0** days. In place of residence **25** years **0** months **0** days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **August 20 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**JULY 1961** to **AUG 20 1964**

I last saw him alive on **AUG 19 1964**, death is said to  
have occurred on the date stated above, at **9 A.** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **BRONCHOPNEUMONIA -**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**24 HRS.**

Due To **ARTERIO-SCLEROTIC HEART**

Due To **DISEASE & PERIPHERAL VASCULAR DISEASE**

**3 YRS.**

OTHER SIGNIFICANT CONDITIONS **SEVERE LEG ULCERS**

**2 YRS.**

Was autopsy performed? **NO.**

What test confirmed diagnosis? **CLINICAL**

5 Was disease or injury in any way related to occupation of deceased **NO**  
If so, specify

(Signature) **Myron H. King** M. D.

**MYRON H. KING M.D.**  
(Print or Type Name)

(Address) **122 Pleasant St. Winthrop** Date **8/20 1964**

6 **Wildwood Cemetery, Winchester**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **August 22 1964**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop**

Received and filed **AUG 21 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)  
**MARRIED** **widowed**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **Ernest Frederick Nelson**  
(Husband's name in full)

12 AGE **88** Years **11** Months **25** Days If under 24 hours  
Hours Minutes

13 Usual Occupation **cook - retired**  
(Kind of work done during most of working life)

14 Industry or Business **own restaurant**

15 Social Security No. **none**

16 BIRTHPLACE (City) **Sweden**  
(State or country)

17 NAME OF FATHER **Johan Gustaf Anderson**

18 BIRTHPLACE OF FATHER (City) **Sweden**  
(State or country)

19 MAIDEN NAME OF MOTHER **Elin Peterson**

20 BIRTHPLACE OF MOTHER (City) **Sweden**  
(State or country)

21 Informant **Mrs. Estelle Taylor**

(Address) **114 Converse St. Malden**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Alfred B. Marsh** (Signature of Agent of Board of Health or other)

**Alfred B. Marsh** (Official Designation) **August 21 1964** (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

# RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1964 PM

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Revere  
(City or Town making this return)

PLACE OF DEATH

Suffolk  
(County)

Revere  
(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No. 152

No. Grover Manor Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Christine Anderson (Cannot be learned) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Mounts Convalescent Home St. Winthrop (City or town and State)

Length of stay: In place of death. years 1 months 20 days. In place of residence 5 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 21, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 1964 to Aug. 21, 1964

I last saw her live on Aug. 21, 1964 death is said to have occurred on the date stated above, at 5:50 P. M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Due To Cerebral Thrombus

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? Clinical signs

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) James F. Burns, M. D.

(Address) 405 Washington Ave. 8/22/64  
Revere

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 24, 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed SEP 4-1964

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Joseph Anderson (Husband's name in full)

12 AGE 77 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Norway

17 NAME OF FATHER Cannot be learned

18 BIRTHPLACE OF FATHER (City) (State or country) Norway

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Norway

21 Informant Chester Anderson

(Address) 507 Shirley St., Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED August 24, 1964



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfilment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



RM R-301

Burial permit  
of Health  
Agent.CTIONS  
OR  
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1 C.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

153

1 E N ROUTE HOSP. (CARNEY) St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME HENRY G. ROBERTS (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR.) WW 1 WW 2

(a) Residence, No. 44 READ ST St. WINTHROP (Usual place of abode) (City or town and State)

Length of stay: In place of years months days. In place of residence 60 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 21 1964 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 19 64, to Aug 21 1964. I last saw him live on Aug 21 1964, death is said to have occurred on the date stated above, at 8:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease yn

(b) arteriosclerosis - gen yn

(c) Diabetes Mellitus 400

OTHER SIGNIFICANT CONDITIONS

Fibrillation

Diagonal ulcer 400

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No If so, specify Joseph G. RIGGALL

(Signature) Joseph G. Riggall, M. D.

(Address) 210 Washington Ave

(Address) WINTHROP, Mass 02323 Date 8-23-64

6 WINTHROP WINTHROP Place of Burial or Cremation (City or Town)

DATE OF BURIAL AUG 24 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY 210 WINTHROP ST WINTHROP ADDRESS

Received and filed AUG 26 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN MARRIED

11 If married, widowed, or divorced HUSBAND of LILLIAN G. (BARRY) ROBERTS (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 64 years 8 Months 19 Days If under 24 hours Hours Minutes

13 Usual Occupation: POLICE OFFICER (RETIRED) (Kind of work done during most of working life)

14 Industry or Business: TOWN OF WINTHROP

15 Social Security No.

16 BIRTHPLACE (City) CHAMPLAIN (State or country) MASS

17 NAME OF FATHER AUGUSTUS ROBERTS

18 BIRTHPLACE OF FATHER (City) CHAMPLAIN (State or country) NY

19 MAIDEN NAME OF MOTHER Marie SENACAL

20 BIRTHPLACE OF MOTHER (City) CHAMPLAIN (State or country) NY

21 Informant MRS LILLIAN G. ROBERTS

(Address) 74 READ ST WINTHROP, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lironi (M.D.) (Signature of Agent of Board of Health or other)

Health Officer 8-24-64 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE MAY 29 1942 .....

DATE OF DISCHARGE MAY 15 1943 .....

RANK, RATING 1<sup>ST</sup> LIEUT ARMY MILITARY POLICE .....

ORGANIZATION AND OUTFIT ARMY .....

SERVICE NUMBER 0 475 352 .....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

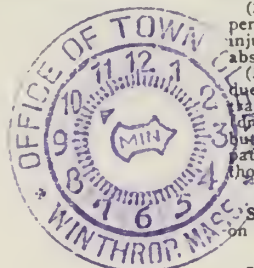
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical drugs or poisons, thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



AUG 2 1964



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop Mass.

(City or Town)

Winthrop Community Hospital

No.

STANDARD

CERTIFICATE OF DEATH

Registered No. 154

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Mr. Samuel Basch**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, **NO**  
if so specify WAR.)

212 Shore Drive

(a) Residence. No.  
(Usual place of abode)

Winthrop Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death... years... months... <sup>33</sup> days. In place of residence... <sup>60</sup> years... months... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **AUGUST 25 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
**11:15** 19 **60** to **AUG 25** 19 **64**  
I last saw him live on **AUG 25** 19 **64** death is said to  
have occurred on the date stated above, at **10:30** m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **NEPHRIC SCLEROSIS C**  
**RESULTANT UREMIA**

(b) **GENERAL ARTERIO SCLEROSIS**

(c) **ARTERIO SCLEROTIC AND**  
**HYPERTENSIVE HEART DIS.**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

6 WKS

4 YRS

OTHER  
SIGNIFICANT  
CONDITIONS **NONE**

Was autopsy performed? **NO**What test confirmed diagnosis? **CLINICAL**

5 Was disease or injury in any way related to occupation of deceased? **NO**  
If so, specify

(Signature) **Myron H. King**, M. D.

(Print or Type Name) **MYRON H. KING**

(Address) **212 SHORE DRIVE** Date **8/25 64**

6 **DAVID VIGOR CHOLIM** **W. Roxbury**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Aug 28** 19 **64**

7 NAME OF FUNERAL DIRECTOR **TORF Funeral Service**

ADDRESS **151 WASHINGTON Ave Chelsea**

Received and filed **AUG 26 1964** 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **M** 9 COLOR **W** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced  
HUSBAND of **PEARL FINKLESTONE**  
(Give maiden name of wife in full)

(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

12 AGE **85** Years... Months... Days If under 24 hours  
Hours... Minutes

13 Usual Occupation: **MANUFACTURER**  
(Kind of work done during most working life)

14 Industry or Business: **CAPS. HEADWEAR**

15 Social Security No. **032-07-2302**

16 BIRTHPLACE (City) **Boston Mass**  
(State or country)

17 NAME OF FATHER **NATHAN B BASCH**

18 BIRTHPLACE OF FATHER (City) **GERMANY**  
(State or country)

19 MAIDEN NAME OF MOTHER **AMELIA CBL**

20 BIRTHPLACE OF MOTHER (City) **GERMANY**  
(State or country)

21 Informant (Address) **BERNARD BASCH**  
**210 Shore Drive Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Schramm**  
(Signature of Agent of Board of Health or other)

**Health Officer** **Aug 26 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



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RULES OF PRACTICE

AUG 26 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301

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Suffolk

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Winthrop Mass.

(City or Town)

Winthrop Community Hospital

No.

## The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 155

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME ~~Mrs~~ Dorcas McGray (Rosswell)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

11 Albert Road

Peabody, Mass.

(a) Residence. No. St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 25 1964.  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
6/22 1964 to 8/25 1964  
I last saw her alive on 8/25 1964 death is said to  
have occurred on the date stated above, at 6 P. m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE,

(a) Carcinoma of Ascending

Due To Colon & Liver Metastasis 3 mos.  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Myocardial Infarction 7/6/64

Was autopsy performed? No

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify No

(Signature) H. H. Potter, M. D.

D. D. Potter, M. D.  
(Print or Type Name)

(Address) 17A Bennington St. E. Boston 8/25 1964

6 Woodlawn Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 28, 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 217 Bennington St. E. Boston

Received and filed Aug. 27, 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED Married  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Charles McGray  
(Husband's name in full)

12 AGE 73 Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. 034-16-2849

16 BIRTHPLACE (City) Nova Scotia  
(State or country)

17 NAME OF FATHER Roswell B. Madden

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Sophronia Moss

20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country)

21 Informant Mrs. Dora Hopp  
(Address) 11 Albert Rd. West Peabody

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-6-62-933104

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Revere  
(City or Town making this return)

Suffolk

(County)

Revere

(City or Town)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 156

No. Grover Manor Hospital

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME Rose Solari (Cicco)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Residence. No. 50 Court Road  
(Usual place of abode)

St. Winthrop  
(City or town and State)

Length of stay: In place of death. years. months. 7 days. In place of residence. 10 years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1964  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from  
Aug. 18 1964 to Aug. 25 1964  
I last saw her alive on Aug. 25 1964 death is said to  
have occurred on the date stated above, at 9 P.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia 48hrs

Due To Carcinoma of bladder 1yr.

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Pathology

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) James P. Burns, M. D.

(Address) 405 Washington Ave. 8/26 64  
Revere

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 29, 1964

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby

ADDRESS Winthrop

Received and filed SEP 4 - 1964 19

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN widowed

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Louis Solari  
(Husband's name in full)

12 AGE 72 Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: Home

15 Social Security No. 034-18-5259

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER James Cicco

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Mary Moschella

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Mrs. Helen Brosnahan

(Address) 50 Court Road, Winthrop

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED August 31, 1964

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

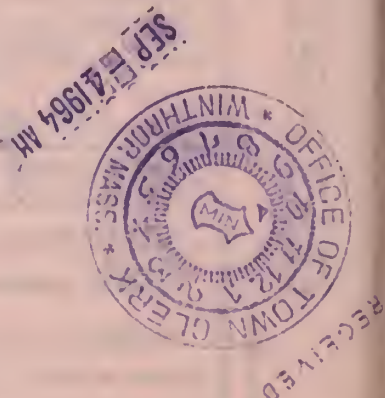
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.





For burial permit  
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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

STANDARD

CERTIFICATE OF DEATH

Registered No. 157

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

2 FULL NAME Josephine (Hooper) Harris  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

(a) Residence. No. 65 Waldemar Ave., Winthrop St. Mass.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. 39 years. 55 months. days. In place of residence. 55 years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 25, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
JAN 1960 to AUG 25 1964  
I last saw him alive on AUG 21 1964 death is said to  
have occurred on the date stated above, at 3:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARCINOMA OF PANCREAS

Due To (b) RESULTANT JAUNDICE

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

GENERAL ATERTOP CLEANS - 5 YRS  
CHOLELITHIASIS & LITHIASIS 3 YRS  
HYPERTENSION 1 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Myron H. King, M.D.  
MYRON H. KING M.D.  
(Print or Type Name)  
(Address) WINTHROP Date 8/25/64

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 28, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed Aug. 27, 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED Widowed  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Alfred Harris  
(Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

12 AGE 87 Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation: Housewife  
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Boston Mass  
(State or country)

17 NAME OF FATHER Charles Hooper

18 BIRTHPLACE OF FATHER (City) Boston Mass  
(State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Boston Mass  
(State or country)

21 Informant Mr. Edmund Harris  
(Address) 526 So 5 th St., San Jose, Cal

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)  
Health Officer (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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For burial permit  
of Health  
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PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL

2 FULL NAME

JAMES E. SPLAINE

(If deceased is a married, widowed or divorced woman, give also maiden name.)

175 WINTHROP ST.

(a) Residence. No.

(Usual place of abode)

St.

WINTHROP

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 28 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from July 20, 1964, to Aug. 28, 1964

I last saw him live on Aug. 28, 1964 death is said to have occurred on the date stated above, at 1030 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) carcinoma of ileum

INTERVAL BETWEEN ONSET AND DEATH

2 mos

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS arteriosclerotic and 5 yrs hypertensive heart disease

Was autopsy performed? No

What test confirmed diagnosis? clinical & lab.

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) M. Traunstein, Jr. M. D.

(Address) 73 Bartlett Rd. Wintthrop

6 Holy Cross Cemetery Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL September 1, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Wintthrop, Mass.

Received and filed AUG 31 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 158

{(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR)

No

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED

WIDOWED

DIVORCED

UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Helen E. Clarke

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AG 89

Years

Months

Days

If under 24 hours

Hours Minutes

13 Usual

Occupation: Retired

(Kind of work done during most working life)

14 Industry

or Business: Hotel Proprietor

15 Social Security No.

011-30-2247

16 BIRTHPLACE (City)

(State or country)

No. Brookfield Mass

17 NAME OF

FATHER

Maurice Splaine

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Ireland

19 MAIDEN NAME

OF MOTHER

Hannah Donahue

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Ireland

21 Informant Helen E. Splaine

(Address)

175 Wintthrop St., Wintthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Seranno (31)

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

For burial permit  
of Health  
Agent.

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **159**

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **no**

2 FULL NAME Enrico E. Uccello (Goracoe)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 159 Buchanan St. Wintrop  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 32 years.....months.....days. In place of residence 32 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 31, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Oct. 16, 1951, to Aug. 31, 1964  
I last saw him alive on Aug. 31, 1964, death is said to  
have occurred on the date stated above, at 10 a.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction 1 hr

Due To (b) Arteriosclerotic & hyper-  
tensive heart disease 14 yrs

Due To (c) General arteriosclerosis 15 yrs

OTHER SIGNIFICANT CONDITIONS Healed duodenal ulcer 1 yr

Was autopsy performed? no  
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased No.  
If so, specify

(Signature) M. Traustein Jr. M. D.

(Address) 73 Bartlett Rd. Sept. 1, 64  
Wintrop, Mass. 02152

6 Wintrop Cemetery, Wintrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 3, 1964

7 NAME OF FUNERAL DIRECTOR James E. Gagliano

ADDRESS 147 Wintrop St. Wintrop

Received and filed SEP 3 - 1964 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Frank Uccello  
(Husband's name in full)

12 AGE 63 Years 8 Months 22 Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No. 024-36-4356

16 BIRTHPLACE (City).....  
(State or country) Italy

17 NAME OF FATHER Ottavio Goracoe

18 BIRTHPLACE OF FATHER (City).....  
(State or country) Italy

19 MAIDEN NAME OF MOTHER Veronica Vilasella

20 BIRTHPLACE OF MOTHER (City).....  
(State or country) Italy

21 Informant Frank Uccello  
(Address) 159 Buchanan St., Wintrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Health officer 9/2/64  
(Signature of Agent of Board of Health or other)  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

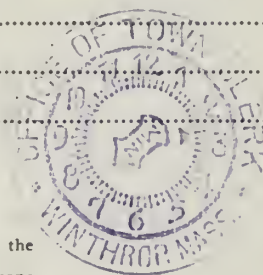
DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



SEP 3 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



For burial permit  
Board of Health  
Agent.

INSTRUCTIONS  
OR  
CERTIFICATE

FOR TYPE  
CAUSES  
DEATH

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OUT OF TOWN  
Suffolk  
(County)  
BOSTON  
(City or Town)



The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

160

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 05526

No. Beth Israel Hospital  
(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran, WW#1  
if so specify WAR)

2 FULL NAME. Norman J. Horrigan  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
150 Washington Ave. Winthrop Mass  
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 50 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 5 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
July 4 1964 to July 5 1964  
I last saw him alive on July 5 1964 death is said to  
have occurred on the date stated above, at 4:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
(a) Hypotensive episode  
(b) Congestive heart failure  
(c) Due To

INTERVAL BETWEEN ONSET AND DEATH  
3 hrs  
4 hrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Arnold Jacobson, M. D.  
(Print or Type Name)  
(Address) Beth Israel Hosp Date 7/7 1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 8 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JUL 8 1964

William J. Kane (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed Divorced UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of Margaret A. Walsh  
(Give maiden name of wife in full)  
(or) WIFE of  
(Husband's name in full)

12 AGE 67 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Retired Electrical Engineer  
(Kind of work done during most of working life)

14 Industry or Business Gen Elec Co

15 Social Security No. 015 -09-5591

16 BIRTHPLACE (City) Charlestown Mass  
(State or country)

17 NAME OF FATHER Jeremiah F. Horrigan

18 BIRTHPLACE OF FATHER (City) Boston Mass  
(State or country)

19 MAIDEN NAME OF MOTHER Julia A. Jacobi

20 BIRTHPLACE OF MOTHER (City) Boston Mass  
(State or country)

21 Informant Margaret A. Horrigan

(Address) 150 Wasington Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Donald E. D. Hoxey  
(Signature of Agent of Board of Health or other)

22682 (Official Designation) 7/7/64 (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

ANSWERED



SEP 11 1964 PM

**OUT - OF - TOWN**

**Suffolk**

(County)

**Boston**

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

**STANDARD**

**CERTIFICATE OF DEATH**

Registered No. **06779**

No. **Children's Hospital Medical Center** (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Gary Hoffman**  
(If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. **19 Pleasant Park Rd.** **Winthrop, Mass.**  
(Usual place of abode) (City or town and State)

Length of stay: In place of death **3** years **23** months **7** days. In place of residence **5** years **3** months **7** days.

**MEDICAL CERTIFICATE OF DEATH**

3 DATE OF DEATH **July 11 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from **March 17 1964** to **July 11 1964**  
I last saw him alive on **July 11 1964**, death is said to have occurred on the date stated above, at **8:20a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
**Small bowel volvulus**

(a) **Small bowel volvulus**

Due To (b) **Small bowel volvulus**

Due To (c) **Small bowel volvulus**

OTHER SIGNIFICANT CONDITIONS

**PERSONAL AND STATISTICAL PARTICULARS**

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word) **SINGLE**  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)

12 AGE **5** Years **3** Months **17** Days If under 24 hours Hours Minutes  
13 Usual Occupation **NONE** (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No. **NONE**

16 BIRTHPLACE (City) **WINTHROP** (State or country) **MASS**

**PARENTS**

17 NAME OF FATHER **EDWARD R HUFFMAN**

18 BIRTHPLACE OF FATHER (City) **CHELSEA** (State or country) **MASS**

19 MAIDEN NAME OF MOTHER **MARGARET M SAFRINE**

20 BIRTHPLACE OF MOTHER (City) **WINTHROP** (State or country) **MASS**

Was autopsy performed? **No**

What test confirmed diagnosis? **Surgery**

5 Was disease or injury in any way related to occupation of deceased? If so, specify **No**

(Signature) **John P. Dixon, M.D.** M. D.  
**300 LONGWOOD AVE 7-11 64**  
(Address) (Date)

6 **HULLY CROSS** **WALDEN**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **JULY 14 1964**

7 NAME OF FUNERAL DIRECTOR **MAURICE W KIRBY**  
**210 WINTHROP ST**  
ADDRESS **WINTHROP MASS**

Received and filed **JUL 15 1964**

21 Informant **MARGARET M SAFRINE**  
(Address) **19 PLEASANT PARK RD WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
**Raymond J. Logerson**  
(Signature of Agent of Board of Health or other)  
**22745** (Official Designation)  
**7/13/64** (Date of Issue of Permit)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

ANSWERED



SEP 11 1964 PM

**OUT - OF - TOWN**  
**SUFFOLK**

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

162

(City or Town making this return)

**BOSTON**

(County)

(City or Town)

**STANDARD**

**CERTIFICATE OF DEATH**

Registered No.

06818

No. **MASSACHUSETTS GENERAL HOSPITAL**

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Margaret Velma M. Mason** (~~Putman~~)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence. No. **18 Cottage Ave.**  
(Usual place of abode)

St. **Winthrop, Mass.**

(City or town and State)

Length of stay: In place of death, years.....months.....days. **14** days. In place of residence. **65** years.....months.....days.

**MEDICAL CERTIFICATE OF DEATH**

3 DATE OF DEATH **July 12 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That "attended deceased from **June 30 64** to **July 12 64**

last saw him alive on **July 12**, 19. **64** death is said to

have occurred on the date stated above, at **11:50 p.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **PERITONEAL HEMORRHAGE**

Due To **HEPATOMA**

(b) **HEPATIC CIRRHOSIS**

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **Yes.**

What test confirmed diagnosis? **Autopsy.**

5 Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....

(Signature) **Charles L. Cloy, M.D.**, M. D.

(Print or Type Name)

(Address) **Asst. Dir., Mass. Gen'l. Hosp.** Date **July 12 1964**

6 **Winthrop Cemetery Winthrop, Mass.**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **July 15, 1964**

7 NAME OF FUNERAL DIRECTOR **Alfred B. Marsh**

ADDRESS **174 Winthrop St. Winthrop,**

Received and filed **JUL 16 1964**

**William J. Rowe** (Registrar)

**PERSONAL AND STATISTICAL PARTICULARS**

8 SEX **female** 9 COLOR **white** 10 SINGLE (write the word)  
MARRIED **married**  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **Thomas Mason**  
(Husband's name in full)

12 AGE **65** Years **5** Months **1** Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation **housewife**  
(Kind of work done during most of working life)

14 Industry or Business **own home**

15 Social Security No. **119-05-1310**

16 BIRTHPLACE (City) **Winthrop**  
(State or country) **Massachusetts**

17 NAME OF FATHER **John R. Putman**

18 BIRTHPLACE OF FATHER (City) **not known**  
(State or country)

19 MAIDEN NAME OF MOTHER **Margaret Taylor**

20 BIRTHPLACE OF MOTHER (City) **Yarmouth**  
(State or country) **Massachusetts**

21 Informant **Thomas Mason**

(Address) **18 Cottage Avenue, Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
Mass and with me BEFORE the burial or transit permit was issued:

**Donald E. DiDomenico**  
(Signature of Agent of Board of Health or other)

**22768**  
(Official Designation)

**7/11/64**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

ANSWERED



SEP 11 1964 PM



**SUFFOLK TOWN**



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

163

(City or Town making this return)

PLACE OF DEATH

(County)  
**BOSTON**

(City or Town)

**MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH**

Registered No. **07115****Massachusetts General Hospital**

No. \_\_\_\_\_ St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME **WILLIAM C MELANSON**(First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)PHYSICIAN — IMPORTANT  
(Was deceased a U. S. War Veteran, if so specify WAR) **no**(a) Permanent Residence. No. **56 Pleasant Street,** St. **Winthrop**  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death. **1** years **12** months **25** days. In place of residence **25** years \_\_\_\_\_ months \_\_\_\_\_ days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **July 22, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

**Intracerebral hemorrhage. Broncho-pneumonia.**

5 Accident, suicide, or homicide (specify) \_\_\_\_\_

Date and hour of injury \_\_\_\_\_ 19\_\_\_\_

IF ACCIDENTAL, was injury causally related to the death? \_\_\_\_\_

Where did Injury occur? \_\_\_\_\_  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? \_\_\_\_\_  
(Specify type of place)Manner of Injury \_\_\_\_\_  
(How did injury occur?)

Nature of Injury \_\_\_\_\_

While at work? \_\_\_\_\_ Was autopsy performed? **Yes**

6 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) **Michael A. Luongo, M.D.**(Address) **Boston** (Print or Type Name) Date **7/22 64**7 **Winthrop Cemetery** **Winthrop**  
Place of Burial or Cremation. (City or Town)DATE OF BURIAL **July 25,** 19**64**8 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**ADDRESS **Winthrop, Mass**Received and filed **Jul 24 1964** 19\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX **Male** 10 COLOR **White** 11 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **Married**12 If married, widowed or divorced HUSBAND of **Amelia Klipp**  
(Give maiden name of wife in full)(or) WIFE of \_\_\_\_\_  
(Husband's name in full)13 AGE **79** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If under 24 hours \_\_\_\_\_ Hours \_\_\_\_\_ Minutes14 Usual Occupation: **Bargemaster**  
(Kind of work done during most of working life)15 Industry or Business: **Shipping Steamship**16 Social Security No. **022-07-5410**17 BIRTHPLACE (City) **Southernville**  
(State or country) **Nova Scotia**18 NAME OF FATHER **Ralph Melanson**19 BIRTHPLACE OF FATHER (City) \_\_\_\_\_  
(State or country) **Nova Scotia**20 MAIDEN NAME OF MOTHER **Rose LeBlanc**21 BIRTHPLACE OF MOTHER (City) \_\_\_\_\_  
(State or country) **Nova Scotia**22 Informant **Amelia Melanson**  
(Address)**56 Pleasant St., Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Leo J. Cogswell**  
(Signature of Agent of Board of Health or other)**22964 July 23, 1964**

A TRUE COPY. ATTEST:

*William J. Kane.*  
City Registrar



OCT - 8 1964 PM

burial permit  
of Health  
Agent.

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP, MASS

(City or Town)

WINTHROP COMMUNITY HOSPITAL

## STANDARD CERTIFICATE OF DEATH

Registered No. 164

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

### PHYSICIAN — IMPORTANT

2 FULL NAME Sophie (Petrukenas) Kozak  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) - No -

(a) Residence, No. 87 Brewster St. Ave St. Winthrop, Mass  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death, 20 days. In place of residence, 17 years - months - days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 2 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from April 19 41, to Sept 2 19 64

I last saw him alive on Sept 2 19 64 death is said to have occurred on the date stated above, at 12:00 P.M.

### DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) metastatic carcinoma

Due To carcinoma of breast

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS Rheumatic heart disease, aortic valve disease, after 3 heart operations

Was autopsy performed? yes  
What test confirmed diagnosis? pathology exam

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) H. B. Greenfield, M. D.

(Print or Type Name)

(Address) 447 Winthrop Ave Date Sept 2 19 64

St. Joseph Cem. Roxbury  
Place of Burial or cremation (City or Town)

DATE OF BURIAL Sept. 5 - 64 19

7 NAME OF FUNERAL DIRECTOR Jos. P. Szewski

ADDRESS 93 Otis St Camb

Received and filed SEP 3 - 1964 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widow

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Joseph Kozak (Husband's name in full)

12 AGE 50 years Months Days 13 If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: at Home

15 Social Security No. none

16 BIRTHPLACE (City) Boston Mass (State or country)

17 NAME OF FATHER Stanislaus Petrukenas

18 BIRTHPLACE OF FATHER (City) Poland (State or country)

19 MAIDEN NAME OF MOTHER Alexandria - C.N.B.L

20 BIRTHPLACE OF MOTHER (City) Poland (State or country)

Charles J Petrukenas

21 Informant (Address) 53 Quimby St Watertown

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
of Health  
Agent.

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATHRegistered No. **165**

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

Adele

PHYSICIAN — IMPORTANT

2 FULL NAME Natalee<sup>A</sup> Gilbert (Close)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.(a) Residence. No. 106 Circuit Rd., st. Winthrop, Mass.  
(Usual place of abode) (If nonresident, give city or town and State)Length of stay: In place of death 2 years 2 months 21 days. In place of residence 57 years 0 months 0 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 9, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
MAY 18, 1964 to Sept 9, 1964  
I last saw him alive on Sept 9, 1964 death is said to  
have occurred on the date stated above, at 3:45 A.M.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia 2 mos.Due To Sub-acute glomerulitis 6 mos.  
(b)Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify(Signature) Nathanial P. Danoff, M. D.Nathanial P. Danoff M.D.  
(Print or Type Name)(Address) 37 Princeton St. E.D. Date Sept. 9, 19646 WOODLAWN CEMETERY, WINTHROP, MASS.  
Place of Burial or Cremation (City or Town)DATE OF BURIAL September 11, 19647 NAME OF FUNERAL DIRECTOR Alfred B. MarshADDRESS 174 Winthrop St. Winthrop, Mass.Received and filed SEP 11 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
widowed  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of Marcellus Nelson Gilbert  
(Give maiden name of wife in full)  
(or) WIFE of Marcellus Nelson Gilbert  
(Husband's name in full)12 AGE 72 Years 4 Months 16 Days If under 24 hours  
Hours Minutes13 Usual Occupation: housework  
(Kind of work done during most working life)14 Industry or Business: own home15 Social Security No. 010-07-804816 BIRTHPLACE (City) Charlestown  
(State or country) Massachusetts17 NAME OF FATHER Samuel Scott Close18 BIRTHPLACE OF FATHER (City) New Brunswick  
(State or country)19 MAIDEN NAME OF MOTHER Isabelle Bradstreet20 BIRTHPLACE OF MOTHER (City) Maine  
(State or country)21 Informant Marcellus N. Gilbert  
(Address)8 Maiden Lane, LynnfieldI HEREBY CERTIFY that a satisfactory standard certificate of death  
has been filed with me BEFORE the burial or transit permit was issued: Ralph E. Sullivan, Jr.   
(Signature of Agent of Board of Health or other)Health Officer 9/11/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

RULES OF PRACTICE

ANSWERED

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly, by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SEP 11 1964 PM



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

## STANDARD

## CERTIFICATE OF DEATH

Registered No. 166

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

## PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)}

2 FULL NAME LoConte, Baby Boy  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

78 Trenton St., East Boston, Mass.

(a) Residence. No. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....8 days..... In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPT. 15 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from 9-14, 1964, to 9-15, 1964.  
I last saw him alive on 9-15, 1964, death is said to have occurred on the date stated above, at 10 AM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac failure

(b) Due To Congenital Anomalies

(c) Due To ANENCEPHALY

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no  
If so, specify

(Signature) Jacob B Burke, M. D.

JACOB B. BURKE  
(Print or Type Name)

(Address) 42 Avenue Ave Date 9-15 1964

6 Holy Cross Cemetery Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 16 1964

7 NAME OF FUNERAL DIRECTOR Vincent Kapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed SEP 16 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) SING/LE  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE.....Years.....Months.....Days 8 Hours 15 Minutes  
If under 24 hours

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business: -----

15 Social Security No. none

16 BIRTHPLACE (City) WINTHROP, MASS.  
(State or country)

17 NAME OF FATHER RICHARD LO CONTE

18 BIRTHPLACE OF FATHER (City) Bronx,  
(State or country) N. Y.

19 MAIDEN NAME OF MOTHER Rinaldi, Angelina

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) MASS.

21 Informant Richard LoConte (father.)  
(Address) 78 Trenton St., East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serrano (3)  
(Signature of Agent of Board of Health or other)  
Health Officer Sept 16 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

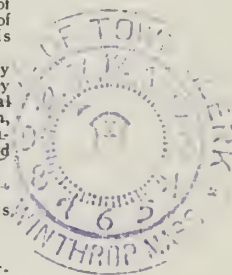
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



SEP 16 1964 AM

burial permit  
of Health  
Agent.

CERTIFICATE

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CAUSES  
OF DEATH

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of dying,  
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# The Commonwealth of Massachusetts



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

## STANDARD CERTIFICATE OF DEATH

Registered No. 167

No. 17 Bartlett Parkway

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)  
PHYSICIAN — IMPORTANT

2 FULL NAME Albert Priestmont Dodson

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Permanent Residence. No. 17 Bartlett Parkway, Winthrop, Massachusetts  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 50 years.....months.....days. In place of residence 50 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 23 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
July 24, 1962, to September 23, 1964

I last saw him alive on Sept. 22, 1964 death is said to  
have occurred on the date stated above, at 6 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction 3 hrs

Due To Arteriosclerotic & hyper-  
(b) tensive heart disease 2 yrs.

Due To Generalized arteriosclero-  
(c) sis 4 yrs.

OTHER SIGNIFICANT CONDITIONS Chronic pulmonary  
fibrosis & emphysema 18 mos.

Was autopsy performed? NO

What test confirmed diagnosis Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased NO  
If so, specify

(Signature) M. Traunstein, Jr., M. D.

M. Traunstein, Jr., M.D.  
(Print or Type Name)

(Address) 73 Bartlett Rd. Date Sept. 24, 1964

6 Winthrop Cemetery Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 25, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed Sept 25 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED  
DIVORCED UNKNOWN

11 If married, widowed, or divorced,  
HUSBAND of Christina Marie Miller  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 Years 6 Months 8 Days If under 24 hours  
Hours Minutes

13 Usual Occupation sales manager  
(Kind of work done during most of working life)

14 Industry or Business wholesale Hardware Co.

15 Social Security No. 011-10-5748

16 BIRTHPLACE (City) East Boston  
(State or country) Massachusetts

17 NAME OF FATHER Dodson

18 BIRTHPLACE OF FATHER (City) Cumberland County  
(State or country) England

19 MAIDEN NAME OF MOTHER Ida May Faust

20 BIRTHPLACE OF MOTHER (City) Revere  
(State or country) Massachusetts

21 Informant Albert M Dodson

(Address) 17 Bartlett Parkway

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Sweeney (Signature of Agent of Board of Health or other)

Health Officer Sept 25 1964  
(Official Designation) (Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
SEP 25 1964 AM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1. Burial permit  
of Health  
Agent.

2. INSTRUCTIONS  
3. CERTIFICATE

4. TYPE  
5. CAUSES  
6. DEATH

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20. e under-  
21. se last.

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23. with but not  
24. the terminal  
25. condition given

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)

No. WINTHROP COMMUNITY HOSPITAL



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 168

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Roy Lanzilli  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO

(a) Residence, No. 8 Sea View Avenue  
(Usual place of abode)

St. Saugus, MASS  
(If nonresident, give city or town and State)

Length of stay: In place of death, years, months, 5 days. In place of residence, years, months, days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH SEPTEMBER 23 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
SEPT 23 1964, to SEPT 23 1964,  
I last saw him alive on SEPT 23 1964, death is said to  
have occurred on the date stated above, at 6:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PRE MATURITY

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
hrs.

Due To (b) PREMATURE SEPARATION of PLACENTA 2 MO

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) D. Thomas Staffier M. D.

(Address) 21 BREEZINGDALE AVE. SEPT 23 1964

NORWOOD MEM.PK. CANTON  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL SEPT. 24 1964

7 NAME OF FUNERAL DIRECTOR L. PIETRO & VAZZA

ADDRESS 11 HENRY STREET, BOSTON  
SEP 24 1964

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years, Months, Days 13 If under 24 hours  
5 Hours, Minutes

13 Usual Occupation: (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. NONE

16 BIRTHPLACE (City) WINTHROP MASS  
(State or country)

17 NAME OF FATHER JOSEPH LANZILLI

18 BIRTHPLACE OF FATHER (City) BOSTON  
(State or country) MASS

19 MAIDEN NAME OF MOTHER JEANNETTE FOX

20 BIRTHPLACE OF MOTHER (City) BROCKTON  
(State or country) MASS

21 Informant (Address) JOSEPH LANZILLI  
8 SEA VIEW AVE.  
SAUGUS, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Soranno (2)  
(Signature of Agent of Board of Health or other)

Health Officer SEP 24 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

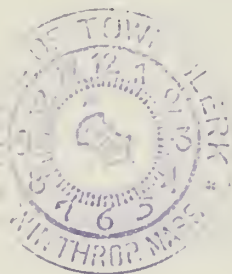
RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED



SEP 24 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



burial permit  
of Health  
Agent.

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Medical examiner notified. referred to Board of Health.

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 169

PLACE OF DEATH

(County)

(City or Town)

No. 170 South St.

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)2 FULL NAME Antonio Rucillo (Antonio Rucillo)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Residence. No. 170 South St.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death 30 years.....months.....days. In place of residence 30 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 27 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....I last saw h.....alive on....., 19....., death is said to  
have occurred on the date stated above, at 2:00A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably dueDue To to natural causes.(b) WINTHROP BOARD OF HEALTH.OTHER SIGNIFICANT CONDITIONS  
Charles Liberman, M.D.Was autopsy performed? .....  
What test confirmed diagnosis? .....5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify .....(Signature) Charles Liberman, M.D.  
CHARLES LIBERMAN(Address) WINTHROP, MASS. Date 9/27/19646 170 South St., Wintrop, Mass.  
Place of Burial or Cremation (City or Town)DATE OF BURIAL Sept. 30 19647 NAME OF FUNERAL DIRECTOR Joseph E. Scudiero  
147 Wintrop St., Wintrop

ADDRESS .....

Received and filed SEP 29 1964 19.....

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Antonio Rucillo  
(Give maiden name of wife in full)(or) WIFE of.....  
(Husband's name in full)12 AGE 33 Years 1 Months 13 Days  
If under 24 hours  
.....Hours.....Minutes13 Usual Occupation: Supermarket  
(Kind of work done during most working life)14 Industry or Business: Supermarket

15 Social Security No.....

16 BIRTHPLACE (City)  
(State or country) Italy17 NAME OF FATHER Antonio Rucillo18 BIRTHPLACE OF FATHER (City)  
(State or country) Italy19 MAIDEN NAME OF MOTHER Thelma Rucillo20 BIRTHPLACE OF MOTHER (City)  
(State or country) Italy21 Informant (Address)  
170 South St., WintropI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Scudiero (a)  
(Signature of Agent of Board of Health or other)Health Officer Sept. 29, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE..... July 22, 1918

DATE OF DISCHARGE..... Jan. 17, 1919

RANK, RATING..... Private

ORGANIZATION AND OUTFIT..... 151st Depot Brigade & Co. A 73rd Infantry Army

SERVICE NUMBER..... 3.149.023

#### RULES OF PRACTICE

RECEIVED



SEP 29 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
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Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. **170**

FACE OF DEATH

**SUFFOLK**  
(County)

**WINTHROP**  
(City or Town)

No. **3 CHESTER AVE**

(If death occurred in a hospital or institution,  
St. (Give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **EDWARD J NOONAN**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO**

(a) Residence. No. **3 CHESTER AVE**  
(Usual place of abode)

St. **WINTHROP**  
(City or town and State)

Length of stay: In place of death **8** years.....months.....days. In place of residence **8** years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **September 29, 1964**  
(Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**MAY 14, 1964** to **Sept 29, 1964**

I last saw him alive on **Sept 28, 1964** Death is said to  
have occurred on the date stated above, at **2:30 P. M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **cerebral vascular accident**

Due To **Arteriosclerosis**

(b)

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS **cerebral vascular accident  
2 years previously**

Was autopsy performed? **NO**

What test confirmed diagnosis? **-**

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify **NO**

(Signature) **H. B. Greenfield**, M. D.

**H. B. Greenfield**  
(Print or Type Name)

(Address) **443 S. WINTHROP ST. WINTHROP, MASS.** Date **Sept 30, 1964**

6 **WYOMING** **MELORE**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **OCT 2, 1964**

7 NAME OF FUNERAL DIRECTOR **MAURILE W KIRBY**

ADDRESS **WINTHROP**

Received and filed **SEP 30 1964** 19.

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX **MALE** 9 COLOR **WHITE** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **MARRIED**

11 If married, widowed, or divorced  
HUSBAND of **BLANCHE LITTLE**  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE **89** Years.....Months.....Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation **BARBER. (RETIRED)**  
(Kind of work done during most of working life)

14 Industry or Business **BARBER.**

15 Social Security No.....

16 BIRTHPLACE (City) **YARMOUTH,**  
(State or country) **N. S.**

17 NAME OF FATHER **DANIAL J NOONAN**

18 BIRTHPLACE OF FATHER (City) **YARMOUTH,**  
(State or country) **N. S.**

19 MAIDEN NAME OF MOTHER **ANNE DANIALS**

20 BIRTHPLACE OF MOTHER (City) **YARMOUTH,**  
(State or country) **N. S.**

21 Informant **MRS BLANCHE NOONAN**  
(Address) **3 CHESTER AVE WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph G. Scurran (3)**  
(Signature of Agent of Board of Health or other)  
**Health Officer** **Sept 30, 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

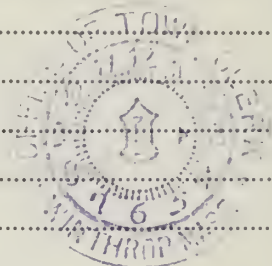
RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RECEIVED



#### RULES OF PRACTICE

SEP 30 1964 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

burial permit  
Agent.

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CERTIFICATE

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PLACE OF DEATH

SUFFOLK

(County)

INTHROP

(City or Town)

No.

INTHROP COMMUNITY HOSPITAL

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

HENRY KELLEY

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

249 PRINCETON STREET

St. E. BOSTON

(a) Residence. No.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....2 days. In place of residence.....20 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH.....SEPTEMBER 30 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
SEPTEMBER 28 1964 to SEPT 30 1964

I last saw him alive on SEPTEMBER 30 1964, death is said to  
have occurred on the date stated above, at 8:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE POSTERIOR CORONARY THROMBOSIS

Due To CORONARY HEART DISEASE

Due To GEN ARTERIOSCLEROSIS

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis? EKG - L.D.H.

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) D. Thomas Staffier, M. D.

D. Thomas STAFFIER MD  
(Print or Type Name)

(Address) 21 BREEZ ST. E. BOSTON Date: SEPT. 30 1964

6 Holy Cross Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 3 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS EAST BOSTON

Received and filed OCT 2 1964

(Registrar)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

## STANDARD CERTIFICATE OF DEATH

Registered No. 171

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

male White MARRIED  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed or divorced  
HUSBAND of Marie M. Pumphrey  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE 68 Years.....Months.....Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: FIREMAN  
(Kind of work done during most working life)

14 Industry or Business: Retired

15 Social Security No. CNBL

16 BIRTHPLACE (City) EAST BOSTON  
(State or country) MASS.

17 NAME OF FATHER Edward Kelley

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER ANN O'BRIEN

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

21 Informant Marie M. Kelley  
(Address) 249 PRINCETON ST. E. BOSTON

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lynam (B)  
(Signature of Agent of Board of Health or other)

Health Officer October 2 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

8-21-18 Pa Sta Boston, Mass

DATE OF DISCHARGE.....

9-30-21 Boston, Mass

RANK, RATING .....

Ship Fitter 2/c (Prov.)

ORGANIZATION AND OUTFIT.....

U. S. NAVY

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OCT 2 1964 AM



ESSEX

(County)

LAWRENCE

(City or Town)

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

COPY OF

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

LAWRENCE

(City or town making return)

Registered No. 864

No. Lawrence General Hospital

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

2 FULL NAME Diane M. Egan

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Residence. No. 16 Maple Road  
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. - years. - months. 1 days. In place of residence. 20 years. - months. - days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 19, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)Acute Cor. Pulmonale due to bilateral  
pulmonary congestion and edema with  
peritonitis due to duodenal rupture  
resulting from #5

5 Accident, suicide, or homicide (specify) Auto Accident

Date and hour of injury abt. 2:00 A.M. 9/18/64

If accidental, was injury causally related to the death? yes

Where did  
Injury occur? North Andover, Mass.  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in  
public place? Isolated Road Junction  
(Specify type of place)Manner of  
Injury Impact  
(How did injury occur?)Nature of  
Injury Duodenal Rupture

While at work? no Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify no

(Signed) John T. Batal, M. D.

(Address) Lawrence, Mass. 9/19/64

Winthrop Cem. - Winthrop, Mass.

Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL September 22, 1964

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby  
ADDRESS Winthrop, Mass.

Received and filed OCT 14 1964 19.

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female 10 COLOR WHITE 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED Single11a If married, widowed, or divorced  
HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 20 Years - Months - Days If under 24 hours  
Hours Minutes14 Usual Occupation: Bank Clerk  
(Kind of work done during most of working life)

15 Industry or Business: Bank

16 Social Security No. - - - - -

17 BIRTHPLACE (City) Winthrop, Mass.  
(State or country)

18 NAME OF FATHER William M. Egan

19 BIRTHPLACE OF FATHER (City) Freeport,  
(State or country) N. Y.

20 MAIDEN NAME OF MOTHER Lillian Bourke

21 BIRTHPLACE OF MOTHER (City) N. Y.  
(State or country) N. Y.22 Informant Lillian Bourke Egan  
(Address) 16 Maple Rd. - Winthrop, Mass.

A TRUE COPY.

ATTEST: Joseph P. Amist  
(Registrar of City or Town where death occurred)

DATE FILED 9/23 1964



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... OCT 14 1964 PM

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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burial permit  
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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 173

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)



No. 457 Shirley St

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Judson F Murray  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) WWI

(a) Residence, No. 457 Shirley St  
(Usual place of abode) St. (City or town and State)

Length of stay: In place of death 6 years months days. In place of residence 6 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 1 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
3-23, 1964, to Oct 1, 1964

I last saw him alive on Oct 1, 1964, death is said to  
have occurred on the date stated above, at 2:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerosis

Due To (c) Diabetes mellitus

OTHER SIGNIFICANT CONDITIONS  
Basal cell carcinoma  
temple

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify No

(Signature) H.B. Greenfield, M. D.

447 Shirley St (Print or Type Name)

(Address) Winthrop Mass Date Oct 1 1964

6 WINTHROP Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 5 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Agnanno

ADDRESS 447 Winthrop St Winthrop

Received and filed OCT 2 1964 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced,  
HUSBAND of Frances Murray (Goss)  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 Years 3 Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Retired Engineer  
(Kind of work done during most of working life)

14 Industry or Business Railroad

15 Social Security No. 706-03-8411

16 BIRTHPLACE (City) Chelsea  
(State or country) Mass

17 NAME OF FATHER Judson Murray

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Alice Ewing

20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country)

21 Informant William Murray  
(Address) 59 Beach Rd Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Scannini

(Signature of Agent of Board of Health or other)

Health Officer

(Date of Issue of Permit) Oct 4 1964

A TRUE COPY ATTEST:

NOTARY PUBLIC

8515



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE..... *May 31, 1918*  
 DATE OF DISCHARGE..... *Aug 14 1919*  
 RANK, RATING..... *Private*  
 ORGANIZATION AND OUTFIT..... *Army Bty C 12th Field Artillery*  
 SERVICE NUMBER..... *385,299*

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Essex

(County)

Saugus

(City or Town)

No. Saugus General Hospital

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Saugus

(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 202

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)2 FULL NAME Katherine Olivia Belcher (Borden)  
(If deceased is a married, widowed or divorced woman, give also maiden name.){(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No(a) Residence, No. 81 Otis St.  
(Usual place of abode)

St. Winthrop

(City or town and State)

Length of stay: In place of death, years, months, 4 days. In place of residence, 70 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 8, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Oct. 5, 1964 to Oct. 8, 1964  
I last saw him on Oct. 8, 1964. Death is said to  
have occurred on the date stated above, at 12:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebrovascular hemorrhage 5 Days

Due To Hypertensive arteriosclerotic  
(b) disease.Due To  
(c)OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? No  
What test confirmed diagnosis? Clinical5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) J. Stanley Capp, M. D.

(Address) 79 Lincoln Ave., Saugus, Mass. Date 10/8 1964

6 Riverside Cemetery, Saugus  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 13, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh  
ADDRESS 174 Winthrop St., Winthrop

Received and filed NOV - 9 1964

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
DIVORCED UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)(or) WIFE of Charles Davis Belcher  
(Husband's name in full)AGE 85 years 9 months 10 days If under 24 hours  
Hours Minutes13 Usual Occupation: Housework  
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Nova Scotia  
(State or country)

17 NAME OF FATHER Charles Alexander Borden

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)19 MAIDEN NAME OF MOTHER Catherine Elizabeth  
Johnstone20 BIRTHPLACE OF MOTHER (City) Nova Scotia  
(State or country)21 Informant Mrs. Harold Carter  
(Address) 81 Otis St., Winthrop, Mass.

A TRUE COPY

ATTEST: John T. Raiche  
(Registrar of City or Town where death occurred)

DATE FILED 10/9/64

Copies of returns of deaths which occurred in your city or town in which the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents; and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV - 9 1964 AM



## The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent.

Suffolk

(County)

Winthrop

(City or Town)

No. Cliff House Nursing Home 170 Cliff Ave. (If death occurred in a hospital or institution,  
its NAME instead of street and number)STANDARD  
CERTIFICATE OF DEATHRegistered No. 1752 FULL NAME Wilfred Bennett

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, No  
if so specify WAR)(a) Residence. No. 224 Cushman Ave.  
(Usual place of abode)St. Revere  
(If nonresident, give city or town and State)Length of stay: In place of death..... years..... months 21 days. In place of residence 60 years..... months..... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 8, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
9/11/64, 1964, to 10/8/64, 1964  
I last saw him alive on 10/8/64, 1964, death is said to  
have occurred on the date stated above, at 6:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary EmphysemaINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
10 yrs.Due To  
(b)Due To  
(c)OTHER SIGNIFICANT CONDITIONS Status Postoperative Carcinoma of Rectum 4 mos.Was autopsy performed? Clinical - Pathological.  
What test confirmed diagnosis No5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify(Signed) Charles Liberman, M. D.  
CHARLES LIBERMAN  
(PRINT OR TYPE SIGNATURE)(Address) WINTHROP, MASS Date 10/8/646 Holy Cross Malden  
Place of Burial or Cremation October 10, 1964  
DATE OF BURIAL (City or town)7 NAME OF FUNERAL DIRECTOR Leslie W. Pike  
ADDRESS 305 Beach St RevereReceived and filed OCT 13 1964 19.....

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX  
Male9 COLOR  
White10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
OR DIVORCED10a If married, widowed, or divorced  
HUSBAND of Anne Clark  
(Give maiden name of wife in full)(or) WIFE of .....  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 65 5 5  
AGE Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation: Carpenter  
(Kind of work done during most of working life)14 Industry or Business: None

15 Social Security No. ....

16 BIRTHPLACE (City) Nova Scotia  
(State or country) Canada17 NAME OF FATHER Frederick Bennett18 BIRTHPLACE OF FATHER (City) Canada  
(State or country)19 MAIDEN NAME OF MOTHER Mary J. Landry20 BIRTHPLACE OF MOTHER (City) Canada  
(State or country)21 Informant Evelyn J. Dalton  
(Address) 1 Congress St. StonehamI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:  
Ralph E. Serianini (mek)  
(Signature of Agent of Board of Health or other)Health Officer 10/9/64  
(Official Designation) (Date of Issue of Permit)

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SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



# RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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Medical Examiner Notified Referred to Board of Health

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)

No. 75 Crest Avenue



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop  
(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

176

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

2 FULL NAME Alba Josephine Mann  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

(a) Residence. No. 75 Crest Avenue  
(Usual place of abode)

St. Winthrop, Mass.  
(City or town and State)

Length of stay: In place of death 25 years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 15, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....

I last saw h..... alive on....., 19....., death is said to  
have occurred on the date stated above, at 2:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

Presumably due to

Due To (b) natural causes

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Winthrop Board of Health  
Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date: 10/15/64

6 Mt. Hope Cemetery Dorchester  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 17, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed OCT 16 1964

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word)  
MARRIED WIDOWED  
DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Joseph Ralph Mann  
(Husband's name in full)

12 AGE 62 Years 4 Months 23 Days

If under 24 hours  
Hours..... Minutes

13 Usual Occupation School teacher  
(Kind of work done during most of working life)

14 Industry or Business Elementary Schools

15 Social Security No. none

16 BIRTHPLACE (City) Malden  
(State or country) Mass.

17 NAME OF FATHER Frank H. Manchester

18 BIRTHPLACE OF FATHER (City) North Adams  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Nettie Law Cunningham

20 BIRTHPLACE OF MOTHER (City) Gardner  
(State or country) Maine

21 Informant Miss. Gail J. Mann

(Address) 75 Crest Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman (R)  
(Signature of Agent of Board of Health or other)

Health Officer Oct 16, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

RULES OF PRACTICE

OCT 16 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No.

Winthrop Community Hospital

Henrietta Taylor

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

15 Belcher Street

(a) Residence. No.

(Usual place of abode)

St.

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....16 days. In place of residence.....5 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 16 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 1958 to Oct 16 1964

I last saw her alive on Oct 16 1964 death is said to have occurred on the date stated above, at 9:58 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial heart disease

(b) arteriosclerosis - generalized

(c)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph Gregorie, M. D.

(Address) 1946 Washington St. Date 10/17 1964

Woodlawn

Everett

6 Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Oct. 19

19

7 NAME OF FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass

Received and filed

OCT 19 1964

19

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No.

177

{(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 AGE 87 Years 2 Months 3 Days

If under 24 hours

Hours. Minutes

13 Usual Occupation: Clerk

(Kind of work done during most of working life)

14 Industry or Business: Bank

15 Social Security No. 024-07-4886

16 BIRTHPLACE (City) East Boston (State or country) Mass

17 NAME OF FATHER Henry Taylor

18 BIRTHPLACE OF FATHER (City) Africa (State or country)

19 MAIDEN NAME OF MOTHER Julia A Moore

20 BIRTHPLACE OF MOTHER (City) Salem (State or country) Mass

21 Informant V Craig Vincent

(Address) 33 Orchard Lane Melrose, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sisson (Signature of Agent of Board of Health or other)

Health Officer (Official Designation)

October 19, 1964 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OCT 19 1964 AM



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

WINTHROP

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 178

PLACE OF DEATH

Suffolk  
(County)  
Winthrop  
(City or Town)

No.

Winthrop Community Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph F. Fielding

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Permanent Residence. No.

179 Faywood Ave. East Boston

(Usual place of abode)

(City or town and State)

Length of stay: In place of death.....years.....months.....3 days. In place of residence.....7 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 18 1964

4. I HEREBY CERTIFY, That I attended deceased from Apr 18 1964, to 10 11 1964

I last saw him alive on 10 11 1964 death is said to have occurred on the date stated above, at 10 15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lung Carcinoma

Due to R Lung Abscess

Due to (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no  
What test confirmed diagnosis? op. Mar 23 1964

5 Was disease or injury in any way related to occupation of deceased? If so, specify no

(Signature) N. W. Potito, M. D.

(Print or Type Name)

(Address) 17A Bennington St. E. B. Date 10-19 1964

6 Holy Cross Malden  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 21 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. MacRath

ADDRESS East Boston

Received and filed OCT 19 1964

John Clark

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED

11 If married, widowed or divorced HUSBAND of NORA A. Christenson (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation Printer (Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 022-07-8506

16 BIRTHPLACE (City or country) East Boston MASS.

17 NAME OF FATHER Joseph F. Fielding

18 BIRTHPLACE OF FATHER (City or country) ENGLAND

19 MAIDEN NAME OF MOTHER Catherine Mulhare

20 BIRTHPLACE OF MOTHER (City or country) LAWRENCE MASS.

21 Informant NORA A. Fielding

(Address) 179 Faywood Ave. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Serrano

(Signature of Agent of Board of Health or other) Death Officer Oct 19, 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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RULES OF PRACTICE

OCT 19 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 179

PLACE OF DEATH

SUFFOLK  
(County)  
WINTHROP  
(City or Town)



No. 32 IRWIN ST. WINTHROP death occurred in a hospital or institution,  
(give its NAME instead of street and number)

2 FULL NAME PETER PANTAZOPOULOS  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

(a) Residence. No. 32 IRWIN ST.  
(Usual place of abode)

St. WINTHROP  
(If nonresident, give city or town and State)

Length of stay: In place of death 11 years months days. In place of residence 11 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 19 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Dec 19 1944 to October 19 1964

I last saw him live on October 15 1964 death is said to  
have occurred on the date stated above, at 3:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

(b) coronary artery disease

(c) coronary arteriosclerosis

OTHER SIGNIFICANT CONDITIONS  
congestive heart failure  
chronic renal infection  
CVA (old)

Was autopsy performed? No

What test confirmed diagnosis? -

5 Was disease or injury in any way related to occupation of deceased? ...  
If so, specify

(Signature) H. B. Greenfield, M. D.

(Address) 47 Church St. WINTHROP

Date Oct 19 64

6 WINTHROP CEM. WINTHROP MASS  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCTOBER 21 1964

7 NAME OF FUNERAL DIRECTOR Anthony C. Hasiotis

ADDRESS 1642 COMMONWEALTH ST. BOSTON

Received and filed OCT 20 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced  
HUSBAND of EUGENIA KAMARINOU  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 89 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation: FRUIT DEALER  
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. NONE

16 BIRTHPLACE (City) GREECE  
(State or country)

17 NAME OF FATHER HERCULES PANTAZOPOULOS

18 BIRTHPLACE OF FATHER (City) GREECE  
(State or country)

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) GREECE  
(State or country)

21 Informant SOPHIA SOROFMAN  
(Address)

30 SPRAY AVE. MARBLEHEAD, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simonson, Jr.  
(Signature of Agent of Board of Health or other)

Health Officer October 20 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....



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RULES OF PRACTICE

OCT 20 1964 PM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

---

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

No.

Cliff House Nursing Home

2 FULL NAME

Riva Brockman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

(Usual place of abode)

162 Franklin Ave

St.

Chelsea

(If nonresident, give city or town and State)

Length of stay: In place of death years months 22 days. In place of residence 40 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

October 20 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/30/1964, to 10/20/1964

I last saw her alive on 10/19/1964, death is said to have occurred on the date stated above, at 10:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Esophagus

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
8mos

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

None

Was autopsy performed?

No

What test confirmed diagnosis

Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed)

Charles Liberman

M. D.

CHARLES LIBERMAN

(PRINT OR TYPE SIGNATURE)

(Address)

WINTHROP, MASS.

Date

10/20/1964

Place of Burial or Cremation

DATE OF BURIAL

Oct 21

(City or Town)

1964

7 NAME OF

ADDRESS

Joy Funeral Home  
Chelsea

Received and filed

OCT 21 1964

19

(Registrar)

## The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHTo be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

180

{(If death occurred in a hospital or institution,  
give its NAME instead of street and number)}

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify War)

No

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
or DIVORCED

10a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Abraham Brockman  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 58

Years — Months — Days

If under 24 hours

Hours — Minutes

13 Usual

Occupation:

Housewife

(Kind of work done during most of working life)

14 Industry

or Business:

Gron Zone

15 Social Security No.

none

16 BIRTHPLACE (City)  
(State or country)

Russia

17 NAME OF FATHER

Jacob Goldfarb

18 BIRTHPLACE OF FATHER (City)

Russia

(State or country)

19 MAIDEN NAME OF MOTHER

E. B. Z.

20 BIRTHPLACE OF MOTHER (City)

Russia

(State or country)

21

Informant

(Address)

Abraham Brockman

162 Franklin Ave Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Siermann (B)

(Signature of Agent of Board of Health or other)

Health officer

October 21, 1964

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

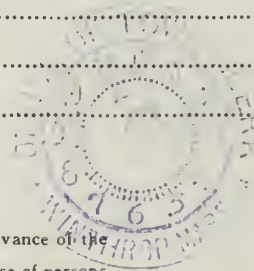
(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.





burial permit  
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Suffolk

(County)

Winthrop

(City or Town)

Winthrop Community Hospital

No.

2 FULL NAME

Messina, Nicholas

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

1134 Brook Rd Milton, Mass.

(Usual place of abode)

Length of stay: In place of death.....years.....months.....7.....days. In place of residence.....years.....4.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

Oct 20

(Month)

(Day)

1964

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Feb 11, 1961, to 10/20, 1964

I last saw him alive on 10/20, 1964 death is said to

have occurred on the date stated above, at 10:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ate. Cirrhosis of liver

Due To Ascites

4 yrs.

(b) Polyserositis (Pick's Dis)

2 wks

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

No

What test confirmed diagnosis?

Chemical tests

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

No

(Signature) H. H. Polite, M. D.

D. D. Polite, M. D.

(Print or Type Name)

(Address) 17A Penn. St. E. B. Date 10/21, 1964

6 Holy Cross Malden

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Oct 23

1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Pagnano

ADDRESS 14 Winthrop St. Winthrop

Received and filed OCT 23 1964

(Registrar)

A TRUE COPY ATTEST:



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD

## CERTIFICATE OF DEATH

Registered No.

181

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

widowed

11 If married, widowed, or divorced

HUSBAND of GUICIA DI GIACOMO

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE 75 Years 1 Months 16 Days

If under 24 hours

Hours.....Minutes

13 Usual

Occupation:

Custodian

(Kind of work done during most working life)

14 Industry

or Business:

Church

15 Social Security No.

030-09-2980A

16 BIRTHPLACE (City)

(State or country)

Compasso

Italy

17 NAME OF

FATHER

Joseph Messina

18 BIRTHPLACE OF

FATHER (City)

Compasso

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Rose ?

20 BIRTHPLACE OF

MOTHER (City)

Compasso

(State or country)

Italy

21 Informant

(Address)

Mrs Josephine Rocato  
1134 Brook Rd Milton Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Preph E. Suranne (R)

(Signature of Agent of Board of Health or other)

Health Officer

October 22 1964

(Official Designation)

(Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

OCT 23 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Everett

(City or Town making this return)

PLACE OF DEATH

Middlesex

(County)

Everett

(City or Town)



COPY OF  
CERTIFICATE OF DEATH

Registered No.

182

No. Whidden Memorial Hospital

(If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

2 FULL NAME Nathan Smolker

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,

No

(a) Residence. No. 161 Washington Ave.

(Usual place of abode)

Winthrop

St. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 20, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1962, to Oct. 20th, 1964I last saw him live on Oct. 20, 1964, death is said to have occurred on the date stated above, at 11:40a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cor pulmonaleINTERVAL  
BETWEEN  
ONSET AND  
DEATH

6 mo

Due To Congestive Heart Failure

(b)

1 yr

Due To Pulmonary Emphysema

(c)

2 yr

OTHER SIGNIFICANT CONDITIONS Chronic Pyelitis

17 yrs

Was autopsy performed? No  
What test confirmed diagnosis? Clinical Lab.5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signed) M. L. Kraft, M. D.  
M. L. Kraft, M.D.(Address) 93 Washington Ave. 10/20/64  
Chelsea6 Sharon Mem. Park Sharon  
Place of Burial or Cremation (City or Town)DATE OF BURIAL Oct. 21, 19647 NAME OF FUNERAL DIRECTOR Torf Funeral ServiceADDRESS 151 Washington Ave. ChelseaReceived and filed OCT 22 1964

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Male

9 COLOR

White

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Married

11 If married, widowed, or divorced  
HUSBAND of Jessie Leondar

(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)12 68 Years.....Months.....Days If under 24 hours  
AGE.....Hours.....Minutes13 Usual Occupation: Pres-Treas.

(Kind of work done during most working life)

14 Industry or Business: Salvage Supply Co.15 Social Security No. None16 BIRTHPLACE (City).....Russia  
(State or country)17 NAME OF FATHER Samuel18 BIRTHPLACE OF FATHER (City).....Russia  
(State or country)19 MAIDEN NAME OF MOTHER Sarah  
CANNOT BE ASCERTAINED20 BIRTHPLACE OF MOTHER (City).....Russia  
(State or country)21 Informant Irving Smolker  
(Address) 161 Washington St. Winthrop

A TRUE COPY

ATTEST: [Signature]  
(Registrar of City or Town where death occurred)DATE FILED Oct. 21, 1964

V.P. ✓



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....



OCT 22 1964 AM

## The Commonwealth of Massachusetts

JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSTo be filed for burial permit  
with Board of Health  
or its Agent. 183STANDARD  
CERTIFICATE OF DEATH

Registered No. 129

Suffolk  
(County)Winthrop  
(City or Town)No. Winthrop Community Hospital (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie Cataldo (Bianco) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 26 Gladstone St. East Boston, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....32 days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 22 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN 1954 to OCT 22 1964

I last saw h. live on OCT 22 1964, death is said to have occurred on the date stated above, at 5:40 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE CORONARY Occ.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

5 HOURS

(b) DUE TO GENERAL ARTERIO-SCLEROSIS  
& ARTERIO-SCLEROTIC HEART DIS 3 YRS(c) DIVERTICULITIS - ACUTE  
& CHRONIC  
PARTIAL OBSTRUCTION  
OF SIGMOID 3 MO.  
OTHER SIGNIFICANT CONDITIONS ANAL ULCER 1 MO

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) Myron N. King M.D.

(PRINT OR TYPE SIGNATURE)

(Address) 211 Pleasant St. Date OCT 22 1964

6 Holy Cross Cemetery, Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 26th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed OCT 22 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Widowed

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Pasquale Cataldo (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years.....Months.....Days If under 24 hours Hours.....Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business At home

15 Social Security No. None

16 BIRTHPLACE (City) Italy (State or country)

17 NAME OF FATHER Lorenzo Bianco

18 BIRTHPLACE OF FATHER (City) Italy (State or country)

19 MAIDEN NAME OF MOTHER Carolina (CBL)

20 BIRTHPLACE OF MOTHER (City) Italy (State or country)

21 Informant John P. Cataldo-son (Address) 60 Bellevue Ave., Winthrop

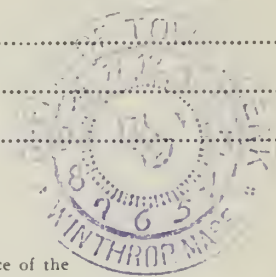
I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (MCK) (Signature of Agent of Board of Health or other)

Health Officer 10/23/64 (Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

RECEIVED



#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



# The Commonwealth of Massachusetts

EDWARD J. CRONIN  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.



## STANDARD CERTIFICATE OF DEATH

Registered No. **184**

PLACE OF DEATH

Suffolk  
(County)

Wintthrop  
(City or Town)

No. **Cliff House Nursing Home**

St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

2 FULL NAME **Bessie Rantz**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

**PHYSICIAN - IMPORTANT**

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. **19 UNDERHILL ST**  
(Usual place of abode)

St. **WINTHROP**

(If nonresident, give city or town and State)

Length of stay: In place of death **1** years **1** months **1** days. In place of residence **15** years **1** months **1** days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **October 22 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from  
**Nov. 1947** to **October 22, 1964**  
I last saw her alive on **Oct. 22, 1964**, death is said to  
have occurred on the date stated above, at **11:45 P.M.**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Coronary Occlusion, acute** **5 min.**

Due To (b) **Hypertensive - Coronary Artery** **10 yrs.**  
**Heart Disease**

Due To (c) **Arteriosclerosis** **10 yrs.**

OTHER SIGNIFICANT CONDITIONS **Surgical Amputation of** **4 yrs.**  
**Left leg**

Was autopsy performed? **No**

What test confirmed diagnosis? **Clinical**

5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify.

(Signed) **Charles Liberman** M. D.  
**CHARLES LIBERMAN**

(Address) **WINTHROP, MASS.** Date **10/22/1964**

6 **WORKMEN'S CIRCLE - MELROSE**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **October 25** **1964**

7 NAME OF FUNERAL DIRECTOR **Morris W. Brezniak**  
ADDRESS **470 Harvard St. Brookline**

Received and filed **OCT 23 1964** 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Female** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED** **WIDOWED**  
or **DIVORCED**

10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **ISRAEL RANTZ**  
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE **83** Years **1** Months **1** Days  
If under 24 hours  
Hours Minutes

13 Usual Occupation: **HOUSE WIFE**  
(Kind of work done during most of working life)

14 Industry or Business: **AT HOME**

15 Social Security No. **UNKNOWN**

16 BIRTHPLACE (City) **RUSSIA**  
(State or country)

17 NAME OF FATHER **JOSEPH FREEDMAN**

18 BIRTHPLACE OF FATHER (City) **RUSSIA**  
(State or country)

19 MAIDEN NAME OF MOTHER **ESTHER (UNKNOWN)**

20 BIRTHPLACE OF MOTHER (City) **RUSSIA**  
(State or country)

21 Informant **MRS. AUGUSTA HENRY**  
(Address) **71 BEAL ST. WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer **October 23, 1964**  
(Official Designation) (Date of Issue of Permit)

EXTRACTS  
FROM THE LAWS OF THE  
COMMONWEALTH OF MASSACHUSETTS  
GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6, as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only those caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



R-301

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

185

Winthrop Community Hospital

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. Joseph Omer Poulin

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

(a) Permanent Residence. No.  
(Usual place of abode)

21 Sturgis St

Winthrop

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 10 30 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Dec. 1962 to Oct. 30, 1964  
I last saw him alive on Oct. 30, 1964, death is said to  
have occurred on the date stated above, at 12:50 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial infarction

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

10 days

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT recurring pulmonary  
CONDITIONS emboli

Was autopsy performed? Yes

What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify No

(Signature) H.B. Greenfield, M.D.

(Print or Type Name)  
444 Shirley St.

(Address) Winthrop Date Oct. 30, 1964

6 Woodlawn Crematory Everett  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 2 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed NOV - 2 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of Perle Hauser  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 58 3 24  
AGE. Years. Months. Days If under 24 hours  
Hours. Minutes

13 Usual Occupation Barber  
(Kind of work done during most of working life)

14 Industry or Business Own Barber Shop

15 Social Security No. 012-01-1317

16 BIRTHPLACE (City) Lewiston  
(State or country) Maine

17 NAME OF FATHER Alfred Poulin

18 BIRTHPLACE OF FATHER Boughton  
(City) Canada  
(State or country)

19 MAIDEN NAME OF MOTHER Philomine Belisle

20 BIRTHPLACE OF MOTHER Lake Magantic  
(City) Canada  
(State or country)

21 Informant Perle Poulin

(Address) 21 Sturgis St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Seemann  
(Signature of Agent of Board of Health or other)

Health officer

(Date of Issue of Permit)

Nov 2 - 1964

48

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

NOV 2 1964 AM

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

186

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 07582

PLACE OF DEATH

SUFFOLK  
(County)  
BOSTON  
(City or Town)



No. BOSTON CITY HOSPITAL

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Fred Coras  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence. No Deer Island  
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years months 3 days. In place of residence years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 6 1964  
(Month) was a patient

I HEREBY CERTIFY that the death of Aug. 3, 1964 to Aug. 6, 1964

I last saw him 3:22 A.M. death is said to have occurred on the date stated above, at

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Obstruction of Superior Vena Cava

(b) Bronchogenic Carcinoma

Due To  
(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

Days  
months

OTHER  
SIGNIFICANT  
CONDITIONS

Sporotrichosis

Was autopsy performed? no  
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) William J. Kane M. D.

M. WINTHROP O'CONNELL M.D.

(Address) BOSTON CITY HOSP. 8-6-64

6 M. J. BENEDICT Boston  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Aug 10 1964

7 NAME OF FUNERAL DIRECTOR J. J. Good & Sons

ADDRESS 336 DUDLEY ST. Rox

Received and filed AUG 11 1964

William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word) SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 57 years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Boiler Maker  
(Kind of work done during most of working life)

14 Industry or Business COMBUSTION ENGINEERING CO

15 Social Security No. 012-16-7542

16 BIRTHPLACE (City) Boston  
(State or country) MASS

17 NAME OF FATHER William Coras

18 BIRTHPLACE OF FATHER (City) England  
(State or country)

19 MAIDEN NAME OF MOTHER HELEN CROOKSHANK

20 BIRTHPLACE OF MOTHER (City) ABERDEEN  
(State or country) SCOTLAND

21 Informant Mrs ANNABELL TERRIER (NEICE)

(Address) 6 SALISBURY PARK DOR.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter Ferrante  
(Signature of Agent of Board of Health or other)

01131 8-10-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



NOV - 4 1964 AM



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burial permit  
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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

187

(City or Town making this return)

08777

Registered No. 33

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

BOSTON SANATORIUM

No. \_\_\_\_\_ St. \_\_\_\_\_ (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME **Morris Mishkind**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No(a) Residence, No. **26 Faun Bar Ave., Winthrop**  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death **0** years **0** months **2** days. In place of residence \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **September 10 1964**  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
**September 8, 1964** to **September 10, 1964**I last saw him alive on **September 10, 1964** death is said to  
have occurred on the date stated above, at **6:40 AM**.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Miliary Tuberculosis**INTERVAL  
BETWEEN  
ONSET AND  
DEATHDue To  
(b)Due To  
(c)OTHER SIGNIFICANT CONDITIONS **Arteriosclerotic Heart Disease**Was autopsy performed? **No**  
What test confirmed diagnosis? **Clinical X-ray**5 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_(Signature) **Benson S. Charif, M.D.** M. D.  
(Print or Type Name)(Address) **249 River St., Date Sept. 10, 1964**6 **Agudas Achim Cem.** **Melrose**  
Place of Burial or Cremation (City or Town)DATE OF BURIAL **Sep. 11** 19 **64**7 NAME OF FUNERAL DIRECTOR **Murray Goldman**ADDRESS **174 Ferry St., Malden**Received and filed **SEP 15 1964** 19 \_\_\_\_\_

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**11 If married, widowed, or divorced  
HUSBAND of **Rose Goldman**  
(Give maiden name of wife in full)(or) WIFE of \_\_\_\_\_  
(Husband's name in full)12 AGE **87** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If under 24 hours  
Hours \_\_\_\_\_ Minutes \_\_\_\_\_13 Usual Occupation: **Grocer**  
(Kind of work done during most working life)14 Industry or Business: **Retired**

15 Social Security No. \_\_\_\_\_

16 BIRTHPLACE (City) **Unknown**  
(State or country) **Poland**17 NAME OF FATHER **Joseph Mishkind**18 BIRTHPLACE OF FATHER (City) **Unknown**  
(State or country) **Poland**19 MAIDEN NAME OF MOTHER **Minnie (Unknown)**20 BIRTHPLACE OF MOTHER (City) **Unknown**  
(State or country) **Poland**21 Informant **Herman Mishkind**  
(Address) **26 Faun Bar Ave., Winthrop**I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:**William J. Hanc**  
(Signature of Agent of Board of Health or other)**03074** **9-14-64**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY OF THE

*William Lloyd*





A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



NOV 27 1964 AM

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27 1964

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OUT - OF - TOWN

PLACE OF DEATH

SUFFOLK

(County)

BOSTON

(City or Town)

BOSTON CITY HOSPITAL



The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD  
CERTIFICATE OF DEATH

189

(City or Town making this return)

09035

Registered No.

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John Fucillo

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, **W. W. I**  
if so specify **W. W. I**)

(a) Permanent Residence, No. **71 WALDEMAR AVE. WINTHROP, MASS.**  
(Usual place of abode) **1255 Somerset Street, East Boston, Mass.**  
(City or town and State)

Length of stay: In place of death years months days. In place of residence years **5** months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 18, 1964

(Month)

(Was a Patient)

4 I HEREBY CERTIFY, that A attended deceased from  
Aug. 25, 1964 to Sept. 18, 1964

I **Julia Picardi** death is said to

have occurred on the date stated above, at **3:45 PM**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiac Arrest

(b) Carcinoma of Pancreas

(c) Metastases

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **No**

What test confirmed diagnosis? **Clinical**

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) **M. Wintthrop O'Connell**, M. D.

(Print or Type Name)

(Address) **BOSTON CITY** Date **Sept. 18, 1964**

6 **HOLY CROSS MALDEN**

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL **SEPT. 22, 1964**

7 NAME OF FUNERAL DIRECTOR **DIPIETRO & VAZZA**

ADDRESS **11 HENRY ST EAST BOSTON**

Received and filed **SEP 23 1964**

**William J. Kane**

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

**MALE WHITE MARRIED**

11 If married, widowed, or divorced  
HUSBAND of **JULIA PICARDI**  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE **70** Years Months Days  
If under 24 hours Hours Minutes

13 Usual Occupation **ELEVATOR OPER. (RETIRED)**  
(Kind of work done during most of working life)

14 Industry or Business **POST OFFICE BLOC.**

15 Social Security No. **021-09-6450**

16 BIRTHPLACE (City) **ITALY**  
(State or country)

17 NAME OF FATHER **ANGELO FUCILLO**

18 BIRTHPLACE OF FATHER (City) **ITALY**  
(State or country)

19 MAIDEN NAME OF MOTHER **ROSE CAPOREALE**

20 BIRTHPLACE OF MOTHER (City) **ITALY**  
(State or country)

21 Informant **JULIA FUCILLO**  
**71 WALDEMAR AVE. WINTHROP**  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with the DEPT. of the burial or transit permit was issued:

**William J. Kane**  
(Signature of Agent of Board of Health or other)

**03191**  
(Official Designation)

**9-22-64**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

1000

1000  
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NOV 27 1964 PM



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

190

(City or Town making this return)

09243

Registered No.

## STANDARD CERTIFICATE OF DEATH

Suffolk  
(County)

Boston  
(City or Town)

The Children's Hospital Medical Center (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Beth Ann Lepor  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 5 Edgehill Road / Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death... years... months... days. In place of residence... years... months... days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 26, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1964, to Sept. 26, 1964

I last saw her alive on Sept. 26, 1964, death is said to have occurred on the date stated above, at 7:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CYSTIC FIBROSIS

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
8 YRS

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS PORTAL HYPERTENSION

Was autopsy performed? YES

What test confirmed diagnosis? SWEAT TEST

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) John D. Burington, M. D.  
(Print or Type Name) JOHN D. BURINGTON  
(Address) 300 Longwood Ave. Date Sept. 26, 64

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept 28 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed SEP 29 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

Female White MARRIED WIDOWED DIVORCED UNKNOWN Single

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 7 Years 11 Months 19 Days 11 under 24 hours Hours Minutes

13 Usual Occupation School (Kind of work done during most of working life)

14 Industry or Business

15 Social Security No None

16 BIRTHPLACE (City New Brunswick  
(State or country) New Jersey)

17 NAME OF FATHER Jack Lepor

18 BIRTHPLACE OF FATHER (City) Brooklyn  
(State or country) New York

19 MAIDEN NAME OF MOTHER Betsy Wickwire

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass

21 Informant Jack Lepor

(Address) 5 Edgehill Rd. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) 03218 9-29-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*  
City Clerk



NOV 27 1964 AM

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

191

(City or Town making this return)

09495

Registered No.

PLACE OF DEATH

Suffolk  
County  
Roxbury  
(City or Town)

STANDARD  
CERTIFICATE OF DEATH

No.

Jewish Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

2 FULL NAME

Morris Abramovitz

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

no

(a) Permanent Residence. No.  
(Usual place of abode)

500 Shirley St.

Windsor, Mass

(City or town and State)

Length of stay: In place of death 7 years 10 months 2 days. In place of residence 20 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from July 1, 1964 to October 2, 1964  
I last saw him alive on October 2, 1964 death is said to have occurred on the date stated above, at 7:35 a.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolism

(b) Status post laparotomy

(c) Intestinal obstruction

OTHER SIGNIFICANT CONDITIONS Chronic Asthma

Was autopsy performed? checked  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) A. Lozano M. D.

(Print or Type Name)

(Address) 420 Harvard Street, Brookline

6 Jewish Deed Holders. Everett  
(Place of Burial or Cremation) (City or Town)

DATE OF BURIAL October 4, 1964

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed OCT 7 1964 19.

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN widower

11 If married, widowed, or divorced HUSBAND of Rena Edidovitz  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 75 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation Maker of Rubber Heels  
(Kind of work done during most of working life)

14 Industry or Business Shoe Factory

15 Social Security No. 034-03-4563

16 BIRTHPLACE (City) Poland  
(State or country)

17 NAME OF FATHER Unknown

18 BIRTHPLACE OF FATHER (City) Poland  
(State or country)

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) Poland  
(State or country)

21 Informant David Abramovitz Son  
(Address) 43-34 Union St N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Date of Issue of Permit)



2011



NOV 27 1964 AM

## The Commonwealth of Massachusetts

192

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 00443

(If death occurred in a hospital or institution,  
State (give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

Regina M. Dore

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence, No. 130 Grover Ave.  
(Usual place of abode)

St. Winthrop, Mass.

(City or town and State)

Length of stay: In place of death..... years..... months..... 21 days. In place of residence..... years..... 6 months..... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 2 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
September 19 64 to October 2 64

I last saw him alive on October 2 1964 death is said to

have occurred on the date stated above, at 10:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Widespread Carcinomatosis, Mos

Due To (b) bronchogenic Carcinoma, right

Due To Left Pleural Effusion days

INTERVAL  
BETWEEN  
ONSET AND  
DEATHOTHER SIGNIFICANT CONDITIONS (c) Squamous Cell Carcinoma  
of Mouth 1 Year

Was autopsy performed? Yes.

What test confirmed diagnosis? Autopsy.

5 Was disease or injury in any way related to occupation of deceased? ..  
If so, specify ..

(Signature) Charles L. Cloy, M.D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct. 2 1964

6 Winthrop Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 5 1964

7 NAME OF FUNERAL DIRECTOR Ernest Plaggiano

ADDRESS 147 Winthrop St Winthrop

Received and filed OCT 17 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William Dore  
(Husband's name in full)12 AGE 57 Years 6 Months 11 Days If under 24 hours  
Hours Minutes13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business at home

15 Social Security No

16 BIRTHPLACE (City) Boston  
(State or country) Mass

17 NAME OF FATHER John J. Sullivan

18 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass

19 MAIDEN NAME OF MOTHER Mary Lynn

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass21 Informant Winthrop Old Age Director  
(Address) Town Hall Winthrop MassI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit) 1964

A TRUE COPY ATTEST.

OF COPY ATTEST:

*William J. Kane*



NOV 27 1964 AM



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1964

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

193

(City or Town making this return)

1966

Registered No.

STANDARD  
CERTIFICATE OF DEATH

## PHYSICIAN — IMPORTANT

1 PLACE OF DEATH Suffolk (County)  
Boston (City or Town)  
No. Beth Israel Hospital (If death occurred in a hospital or institution, St. (give its NAME instead of street and number))  
2 FULL NAME Joseph Rabinovitz (If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Permanent Residence. No. 33 Tewksbury St. Winthrop, Mass. (City or town and State)  
Length of stay: In place of death 1 years 1 months 1 days. In place of residence 1 years 1 months 1 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 10 1964  
(Month) (Day) (Year)  
4 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1964 to Oct. 10, 1964  
I last saw him alive on Oct. 10, 1964 death is said to have occurred on the date stated above, at 10:35 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cardiovascular Collapse(b) Acute Myocardial Infarct(c) Arteriosclerotic H. Dz.OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Alan M. Siegal M. D.(Print or Type Name) ALAN M. SIEGAL(Address) 330 Brookline Ave Date Oct. 10, 19646 Jewish Deed Holders, Everett  
Place of Burial or Cremation (City or Town)DATE OF BURIAL October 11, 19647 NAME OF FUNERAL DIRECTOR Benjamin F. SolomonADDRESS 420 Harvard Street, BrooklineReceived and filed OCT 14 1964William J. Kane  
(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Rebecca Perman  
(Give maiden name of wife in full)

(or) WIFE of Rebecca Perman  
(Husband's name in full)

12 AGE 72 Years 10 Months 10 Days  
If under 24 hours 10 Hours 10 Minutes

13 Usual Occupation Merchant (retired)  
(Kind of work done during most of working life)

14 Industry or Business Dry Goods

15 Social Security No.

16 BIRTHPLACE (City). Russia  
(State or country)17 NAME OF FATHER (unknown) Rabinovitz18 BIRTHPLACE OF FATHER (City). Russia  
(State or country)19 MAIDEN NAME OF MOTHER Wilda (unknown)20 BIRTHPLACE OF MOTHER (City). Russia  
(State or country)21 Informant Louis Rabinovitz  
(Address) 159 Nahant Avenue, Winthrop,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Sella Oct 10, 1964  
(Signature of Agent of Board of Health or other)Oct 10, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

THE COPY ATTEST:

*William J. Kane.*



NOV 27 1964 AM

RM R-301

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**CITY OF TOWN**

**SUFFOLK**

(County)

**BOSTON**

(City or Town)



No **MASSACHUSETTS GENERAL HOSPITAL**

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

194

(City or Town making this return)

**STANDARD  
CERTIFICATE OF DEATH**

Registered No. **09882**

(If death occurred in a hospital or institution,  
St. ( give its NAME instead of street and number)  
**PHYSICIAN — IMPORTANT**

2 FULL NAME **Albert L. Taylor**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(Was deceased a U. S. War Veteran, **No**  
if so specify WAR)

(a) Residence. No. **117A Locust St.** St. **Winthrop, Mass.**  
(Usual place of abode) (City or town and State)

Length of stay: In place of death **16** years **34** months **34** days. In place of residence **34** years **34** months **34** days.

**MEDICAL CERTIFICATE OF DEATH**

3 DATE OF DEATH **October 14 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that deceased died from  
**September 28 64 to October 14 64**  
last saw him live on **October 14 64** death is said to

have occurred on the date stated above, at **8:00 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Broncho pneumonia.**

Due To (b) **Perforated ileal ulcer.**

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **No.**

What test confirmed diagnosis? **Clinical.**

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) **Charles L. Cloy** M. D.

**Charles L. Cloy, M.D.**

(Print or Type Name)

(Address) **Ass't. Dir., Mass. Gen'l. Hosp.** Date **Oct. 14 19 64**

6 **Winthrop** **Winthrop**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **October 17 64**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop, Mass**

Received and filed **OCT 19 1964**

(Registrar)

**PERSONAL AND STATISTICAL PARTICULARS**

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed, or divorced  
HUSBAND of **Mabel Tyler**  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

AGE **84** Years **5** Months **14** Days If under 24 hours  
Hours Minutes

13 Usual Occupation: **Engineer**  
(Kind of work done during most of working life)

14 Industry or Business: **Stationary**

15 Social Security No **024-07-3113**

16 BIRTHPLACE (City) **Fort Worth**  
(State or country) **Texas**

17 NAME OF FATHER **Unable to obtain**

18 BIRTHPLACE OF FATHER (City) **Unable to obtain**  
(State or country)

19 MAIDEN NAME OF MOTHER **Unable to obtain**

20 BIRTHPLACE OF MOTHER (City) **Unable to obtain**  
(State or country)

21 Informant **Mabel St George**  
(Address) **20 S Main St. Winthrop, Mass.**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

**04870** **Oct. 15, 1964**

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



ALL COPY ATTEST:

*William J. Kane.*  
1711 8000-12



NOV 27 1954 AM

2 FULL NAME Maria Mulhern  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(a) Residence, No. 215 Court St. Winthrop Massachusetts  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years 6 months 5 days. In place of residence 5 years 6 months 5 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 20 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that she attended deceased from Sept. 15, 1964 to Oct. 20, 1964  
last saw him alive on Oct. 20, 1964 death is said to have occurred on the date stated above, at 9:20P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
Carcinoma of Pancreas with  
(a) Peritoneal Carcinomatosis  
Due To  
(b)  
Due To  
(c)

INTERVAL BETWEEN ONSET AND DEATH  
UNK.  
MO.

OTHER SIGNIFICANT CONDITIONS  
Pulmonary Edema  
UNK.  
YRS.

Was autopsy performed? Yes  
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? None  
If so, specify None

(Signature) Charles L. Clay, M. D.  
Charles L. Clay, M.D.  
(Print or Type Name)  
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct. 20 1964

6 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCT. 18 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY  
210 WINTHROP ST. WINTHROP  
ADDRESS

Received and filed OCT 23 1964 1964

8 SEX FEMALE 9 COLOR WHITE 10 SINGLE (write the word) SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of JOHN MULHERN  
(Give maiden name of wife in full)  
(or) WIFE of None  
(Husband's name in full)

12 AGE 79 Years 9 Months 5 Days If under 24 hours Hours 0 Minutes  
13 Usual Occupation COOK (RETIRED)  
(Kind of work done during most of working life)

14 Industry or Business DOMESTIC

15 Social Security No. NONE

16 BIRTHPLACE (City) IRELAND  
(State or country)

17 NAME OF FATHER JOHN MULHERN

18 BIRTHPLACE OF FATHER (City) IRELAND  
(State or country)

19 MAIDEN NAME OF MOTHER CATHERINE BUTLER

20 BIRTHPLACE OF MOTHER (City) IRELAND  
(State or country)

21 Informant MRS CATHERINE MEDIAN  
(Address) 215 COURT RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:  
See [Signature]  
(Signature of Agent of Board of Health or other)  
04860 OCT 21 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

1000  
A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



NOV 27 1964 AM



X OUT - OF - TOWN

SUFFOLK

(County)

ROXBURY

(City or Town)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD

CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

10420

JEWISH MEMORIAL HOSPITAL (If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LOUIS SPRINGER  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

(a) Permanent Residence. No.  
(Usual place of abode)

30 CUTLER Street

St. WINTHROP

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 22 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER 28 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
9:30 to OCTOBER 28 1964I last saw him alive on OCTOBER 28 1964, death is said to  
have occurred on the date stated above, at 7:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHO-PNEUMONIA

(b) DUE TO ARTERIO-SCLEROTIC HEART  
DISEASE WITH CONGESTIVE  
(c) HEART FAILUREINTERVAL  
BETWEEN  
ONSET AND  
DEATH  
DAYS.

YEARS

OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? NO  
What test confirmed diagnosis? CLINICAL5 Was disease or injury in any way related to occupation of deceased?  
If so, specify(Signature) Marc Jacamuli M.D. M. D.  
MARC JACAMULI(Print or Type Name)  
JEWISH MEMORIAL HOSPITAL Date 10 28 19646 BETH JOSEPH #3 - WOBURN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL OCTOBER 30 1964

7 NAME OF FUNERAL DIRECTOR ARNOLD GOLDB

ADDRESS 1668 BEACON ST. BROOKLINE

Received and filed NOV 2 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of MARY STALLINGS  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 81 Years 7 Months 19 Days If under 24 hours  
Hours Minutes13 Usual Occupation FRUIT + PRODUCE BROKER  
(Kind of work done during most of working life)

14 Industry or Business RETIRED

15 Social Security No. 621-28-3156

16 BIRTHPLACE (City) RUSSIA  
(State or country)

17 NAME OF FATHER JACOB SPRINGER

18 BIRTHPLACE OF FATHER (City) RUSSIA  
(State or country)

19 MAIDEN NAME OF MOTHER ANNE KENDALL

20 BIRTHPLACE OF MOTHER (City) RUSSIA  
(State or country)21 Informant MRS. SELMA GOLDBERG  
(Address) 84 CLINTON RD., BROOKLINEI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

04774 10-30-64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.9

DO COME ATTEST:

*William J. Kane.*  
C. O. McQuinn

NOV 27 1964 PM

R-301

Suffolk

(County)

Winthrop

(City or Town)



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

198

No. Winthrop Community Hospital

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

## PHYSICIAN — IMPORTANT

2 FULL NAME Chavis (Baby) Female  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. 63 Lincoln Street,  
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death, years.....months.....days.....  
In place of residence, years.....months.....days.....

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 1 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Nov. 1 1964, to Nov. 1 1964.

I last saw her alive on Nov. 1 1964 death is said to  
have occurred on the date stated above, at 1:02 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

(a) Prematurity (20 weeks)

1 hr.

Due To

(b)

&amp; 33 min.

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Maurice Traustein, Jr., M.D.

Maurice Traustein, Jr., M.D.

(Print or Type Name)

(Address) 73 Bartlett Rd.  
Winthrop, Mass.

Date Nov. 1 1964

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 3 1964

7 NAME OF  
FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed NOV - 3 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female

White

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

Single

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12

AGE.....Years.....Months.....Days

If under 24 hours

1 Hours 33 Minutes

13 Usual

Occupation:

(Kind of work done during most working life)

14 Industry

or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop  
(State or country) Mass.

17 NAME OF

FATHER

Alvin Chavis

18 BIRTHPLACE OF

FATHER (City)

South Hill

(State or country)

Virginia

19 MAIDEN NAME

OF MOTHER

Karin Broberg

20 BIRTHPLACE OF

MOTHER (City)

Winthrop

(State or country)

Mass.

21 Informant

(Address)

Bernice Broberg

Winthrop Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Sweeney (A)

(Signature of Agent of Board of Health or other)

Health officer

(Official Designation)

Nov 3-1964

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### 

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. 199

PLACE OF DEATH

~~Winthrop~~ Suffolk  
(County)



Winthrop

(City or Town)

No. 138 Locust Way

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Grace B Knickerbocker  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 138 Locust Way  
(Usual place of abode)

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death 6 years months days. In place of residence 6 years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 1, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw him alive on 19, death is said to have occurred on the date stated above, at 3:22 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due to natural causes.

(b) Due To Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed? No  
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M.D.

(Address) CHARLES LIBERMAN  
(Print or Type Name)  
WINTHROP, MASS. Date 10/1/1964

6 Greenwood Cemetery St. Alban's, Vt.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 4 1964

7 NAME OF FUNERAL DIRECTOR Charles B Watson Inc

ADDRESS Cambridge, Mass.

Received and filed NOV - 4 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX F 9 COLOR W 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of

(or) WIFE of XXXX John F Knickerbocker  
(Give maiden name of wife in full)  
(Husband's name in full)

12 AGE 56 Years 2 Months 19 Days If under 24 hours Hours Minutes

13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business At home

15 Social Security No. 024-07-5836

16 BIRTHPLACE (City) Swanton Vermont  
(State or country)

17 NAME OF FATHER Frank Brown

18 BIRTHPLACE OF FATHER (City) Vermont  
(State or country)

19 MAIDEN NAME OF MOTHER Mina Blake

20 BIRTHPLACE OF MOTHER (City) Vermont  
(State or country)

21 Informant John F Knickerbocker

(Address) 138 Locust Way, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Serianne (3)  
(Signature of Agent of Board of Health or other)

Health Officer  
(Official Designation)

November 3, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....

ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



NOV - 4 1964 AM

024-07-5836



# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **230**

PLACE OF DEATH

Suffolk  
(County)

Winthrop  
(City or Town)

No. **15 Floyd Street**

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

Frank C. Gorman

PHYSICIAN — IMPORTANT

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, No  
if so specify WAR)

(a) Residence, No. **15 Floyd Street**  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, **50** years.....months.....days. In place of residence **50** years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **November 3, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Dec. 24, 1957** to **Nov. 3, 1964**  
I last saw him alive on **Nov. 2, 1964** death is said to  
have occurred on the date stated above, at **10:30 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute myocardial infarction 1 hr.**

(b) **arteriosclerotic heart disease with coronary sclerosis**  
(c) **Generalized arteriosclerosis 7 yrs.**

OTHER  
SIGNIFICANT  
CONDITIONS

**NONE**

Was autopsy performed?

**no**

What test confirmed diagnosis? **Clinical & laboratory**

5 Was disease or injury in any way related to occupation of deceased? **NO**  
If so, specify

(Signature) **M. Traunstein, Jr.**, M. D.

(Print or Type Name)  
**M. Traunstein, Jr., M. D.**

(Address) **73 Bartlett Rd., Nov. 3, 1964**  
**Winthrop, Mass. 02152**

6 **Winthrop** **Winthrop**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **November 6, 1964**

7 NAME OF FUNERAL DIRECTOR **Arthur J. O'Maley**

ADDRESS **Winthrop, Mass.**

Received and filed **Nov. 5, 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **Male** 9 COLOR **White** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN**

11 If married, widowed or divorced  
HUSBAND of **Edith Martin**  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE **78** Years.....Months.....Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation: **Attorney at Law**  
(Kind of work done during most working life)

14 Industry or Business: **Law**

15 Social Security No. **049-28-5368**

16 BIRTHPLACE (City) **Tariffville Conn**  
(State or country)

17 NAME OF FATHER **William J. Gorman**

18 BIRTHPLACE OF FATHER (City) **Cannot be learned**  
(State or country)

19 MAIDEN NAME OF MOTHER **Anna B. Eaton**

20 BIRTHPLACE OF MOTHER (City) **M. Adams**  
(State or country) **Mass**

21 Informant (Address) **Phillip Gorman**  
**15 Floyd St., Winthrop, Mass**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph A. Surran (3)**  
(Signature of Agent of Board of Health or other)

**Health Officer** **Nov 5, 1964**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

REG. T.M.M.

1.B.V

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



NOV 5 1964 AM

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD

CERTIFICATE OF DEATH

Registered No.

201

No. 225 Pleasant Street

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

Annie L (Parkhurst) Loomis

(Was deceased a U. S. War Veteran, if so specify WAR)

138 Court Road

(a) Residence. No.

(Usual place of abode)

1 Hour

St.

(City or town and State)

Length of stay: In place of death... years... months... days. In place of residence... years... months... days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

November 3, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

19... to 19... death is said to

have occurred on the date stated above, at 1:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

to natural causes, Pulmonary

(b) emphysema and fibrosis

(c) most likely on basis of history.

OTHER SIGNIFICANT CONDITIONS

Winthrop Board of Health  
Charles Liberman, M.D.

Was autopsy performed?

No.

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M.D.

CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date Oct. 4 1964

6 Forrest Hill

Fitchburg, Mass.

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL

Nov. 6

1964

7 NAME OF FUNERAL DIRECTOR

Howard S Reynolds

ADDRESS

Winthrop, Mass.

Received and filed

November 5,

1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

Female

9 COLOR

White

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Widow

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Frederic C Loomis

(Husband's name in full)

12

AGE

71

Years

4

Months

17

Days

If under 24 hours

Hours Minutes

13 Usual Occupation

Assessor

(Kind of work done during most of working life)

14 Industry or Business

State Tax Office

15 Social Security No.

None

16 BIRTHPLACE (City)

Everett

(State or country)

Mass.

17 NAME OF FATHER

Fred L Parkhurst

18 BIRTHPLACE OF FATHER (City)

Unable to obtain

(State or country)

New York

19 MAIDEN NAME OF MOTHER

Celeste E Thurston

20 BIRTHPLACE OF MOTHER (City)

Unable to obtain

(State or country)

New Hampshire

21 Informant

Charles P Loomis

(Address)

138 Court Rd. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Frederic C Loomis

(Signature of Agent of Board of Health or other)

Health Officer

Nov 5, 1964

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

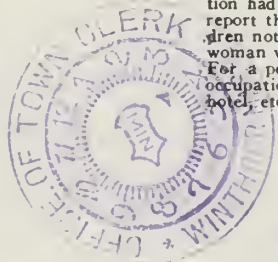
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



NOV 15 1966

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSWinthrop  
(City or Town making this return)STANDARD  
CERTIFICATE OF DEATH

Registered No. 202

PLACE OF DEATH

Suffolk  
(County)Winthrop  
(City or Town)

House

No. Cliff Nursing Home

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John McInnis  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.(a) Permanent Residence. No. 71 Grovers Avenue  
(Usual place of abode) St. (City or town and State)

Length of stay: In place of death years months 2 days. In place of residence 28 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 8 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Sept. 1962 to Nov. 8 1964I last saw him alive on Nov. 7 1964, death is said to  
have occurred on the date stated above, at 8:00 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebro Vascular 2 mos.

(b) Due To Occlusion

(c) Due To Cerebral Arteriosclerosis 2 yrs

OTHER  
SIGNIFICANT  
CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date 11/8/1964

6 Winthrop Cemetery Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 10 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Wintthrop St. Winthrop,

Received and filed NOV 10 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Madeline Graffon  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 86 years 6 Months 8 Days If under 24 hours  
Hours Minutes13 Usual Occupation retired seaman  
(Kind of work done during most of working life)

14 Industry or Business Chief Officer E.S.S. Lines

15 Social Security No. 020-12-9219

16 BIRTHPLACE (City) Cape Breton Island  
(State or country) Canada

17 NAME OF FATHER Norman McInnis

18 BIRTHPLACE OF FATHER (City) Canada  
(State or country)

19 MAIDEN NAME OF MOTHER Bella McCauley

20 BIRTHPLACE OF MOTHER (City) Canada  
(State or country)

21 Informant Mrs. John McInnis

(Address) 71 Grovers Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer Nov 10-1964

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

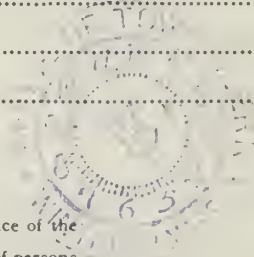
(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



NOV 10 1964 PM



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 203

PLACE OF DEATH

SUFFOLK  
(County)WINTHROP  
(City or Town)

No. CAIFF HURIE NURING HOME

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME. MARY GOLD  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No(a) Residence. No. 115 NAHANT St. LYNN  
(Usual place of abode)

(City or town and State)

Length of stay: In place of death. 2 years. 8 months. 8 days. In place of residence. 52 years. - months. - days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 10 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
Aug 2, 19.64, to Nov. 10, 19.64  
I last saw Deceased on Nov. 9, 19.64, death is said to  
have occurred on the date stated above, at 1.30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Arteriosclerosis 2yrs

Due To  
(b)Due To  
(c)OTHER SIGNIFICANT CONDITIONS Parkinson's Syndrome 2yrs.  
Decubitus ulcers 5 months

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M. D.

CHARLES LIBERMAN  
(Print or Type Name)

(Address) WINTHROP, MASS. Date. 11/10/ 19.64

6 ANAHIS ACHIM LYNN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV 11 19.64

7 NAME OF FUNERAL DIRECTOR Louis Hymowitz

ADDRESS Lynn, Mass

Received and filed NOV 12 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write-the word)

FEMALE WHITE MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of THOMAS GOLD  
(Husband's name in full)12 AGE 78 Years 7 Months 13 Days If under 24 hours  
Hours Minutes13 Usual Occupation HOUSEWIFE  
(Kind of work done during most of working life)

14 Industry or Business AT HOME

15 Social Security No. NONE

16 BIRTHPLACE (City). RUSSIA  
(State or country)

17 NAME OF FATHER JACOB KRASNOGOR

18 BIRTHPLACE OF FATHER (City). RUSSIA  
(State or country)

19 MAIDEN NAME OF MOTHER LILIAN - UNKNOWN

20 BIRTHPLACE OF MOTHER (City). RUSSIA  
(State or country)

21 Informant ETHEL KEVINE - DAUGHTER

(Address) 1088 HUMPHREY ST. SWANSCOTT

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Swann (R)  
(Signature of Agent of Board of Health or other)Health Officer  
(Official Designation)Nov. 10, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

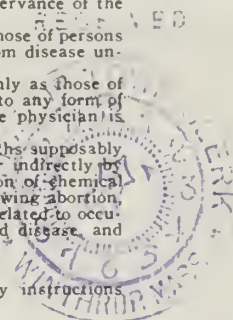
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.







SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

#### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **205**

Suffolk

(County)

Winthrop

(City or Town)

No. **Mayflower Nursing Home**

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **George N Berry**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence. No. **34 Neptune Ave**  
(Usual place of abode)

St. \_\_\_\_\_  
(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence **55** years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **November 16 19 64**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Dec 10 19 50**, to **Nov 16 19 64**  
I last saw him alive on **Nov 13 19 64** death is said to  
have occurred on the date stated above, at **6:30 p.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **UREMIA**

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

**2 yrs.**

Due To

(b) **urine of prostate**

**4 yrs.**

Due To

(c) \_\_\_\_\_

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **No**

What test confirmed diagnosis? **OPX 4.1**

5 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify **NY**

(Signature) **H B Greenfield**, M. D.

(Address) **447 Charles St** (Print or Type Name)

Date **Nov 16 19 64**

6 **Winthrop** **Winthrop**

Place of Burial or Cremation (City or Town)

DATE OF BURIAL **Nov. 18** 19 **64**

7 NAME OF FUNERAL DIRECTOR **Howard S Reynolds**

ADDRESS **Winthrop Mass**

Received and filed **NOV 17 1964** 19 \_\_\_\_\_

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX

**Male**

9 COLOR

**White**

10 SINGLE (write the word)

MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

**Married**

11 If married, widowed or divorced  
HUSBAND of **Georgiana Burdick**

(Give maiden name of wife in full)

(or) WIFE of \_\_\_\_\_  
(Husband's name in full)

12 AGE **84** Years **6** Months **28** Days

If under 24 hours  
Hours Minutes

13 Usual Occupation **Plumber**

(Kind of work done during most of working life)

14 Industry or Business **Self Employed**

15 Social Security No. **None**

16 BIRTHPLACE (City) **Concord**  
(State or country) **New Hampshire**

17 NAME OF FATHER

**Charles Berry**

18 BIRTHPLACE OF FATHER (City)

**Unable to Obtain**

(State or country)

19 MAIDEN NAME OF MOTHER

**Mercy Harris**

20 BIRTHPLACE OF MOTHER (City)

**Unable to Obtain**

(State or country)

21 Informant **Georgiana Berry**

(Address) **34 Neptune Ave. Winthrop, Mass**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Soriani (MCK)**  
(Signature of Agent of Board of Health or other)

**Health Officer**  
(Official Designation)

**11/17/64**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....



NOV 7 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

WINTHROP COMMUNITY HOSPITAL

STANDARD

## CERTIFICATE OF DEATH

Registered No.

206

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

Richard H. Stead

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

No

(a) Permanent Residence. No. 12 Cove St. Revere  
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death.....years.....months3.....days. In place of residence25.....years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 11 16 64  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from

Sept, 19 64, to 11-16- 64

I last saw him alive on 11-15, 1964 death is said to have occurred on the date stated above, at 8:45 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerotic heart disease

Due To (c) arteriosclerotic heart

OTHER SIGNIFICANT CONDITIONS Congestive heart failure

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify W

(Signature) H. B. Greenfield, M. D.

H. B. Greenfield  
(Print or Type Name)

(Address) 477 Sunrise St. Wintthrop Date 11-16 19 64

6 Puritan Lawn Peabody

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 18, 1964 19

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St Revere

Received and filed NOV 18 1964 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Widowed WIDOWED DIVORCED UNKNOWN

11 If married, widowed or divorced HUSBAND of Josephine (Unable to Learn) (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 64 Years 20 Months Days If under 24 hours Hours Minutes

13 Usual Occupation Machinist (Kind of work done during most of working life)

14 Industry or Business Baldwin-Lima-Hamilton

15 Social Security No. 210-05-2757

16 BIRTHPLACE (City) Everett (State or country) Mass.

17 NAME OF FATHER Harry G. Stead

18 BIRTHPLACE OF FATHER (City) Unable to Learn (State or country)

19 MAIDEN NAME OF MOTHER Hannah Johnston

20 BIRTHPLACE OF MOTHER (City) England (State or country)

21 Informant Eva M. Madsen 45 Elliot Rd. Revere

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Carph E. Serrano  
(Signature of Agent of Board of Health or other)

Health Officer  
(Official Designation)

Nov 18 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

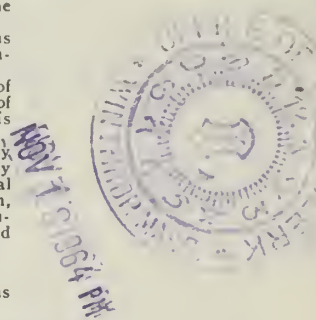
(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



PLACE OF DEATH

SUFFOLK  
(County)WINTHROP  
(City or Town)

## The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

## STANDARD

## CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

207

No. CLIFF HOUSE NURSING HOME. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)2 FULL NAME George Lenas  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO(a) Residence. No. 21 DUNN Rd St. REVERE, MASS.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....1.....months.....days. In place of residence 15 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 17 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
Nov. 10, 1964, to Nov. 17, 1964  
I last saw him live on Nov. 10, 1964, death is said to  
have occurred on the date stated above, at 10:00 p.m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

weeks

months

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Carcinoma of Lung

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? operation

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signed) Joseph A. Regone, M. D.

(Address) 194 Washington St. Date Nov. 17, 1964

6 HILLCREST SPRINGFIELD MASS.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOVEMBER 20, 1964

7 NAME OF FUNERAL DIRECTOR PAUL BUONFIGLIO

ADDRESS 128 REVERE ST. REVERE

Received and filed NOV 18 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR W 10 SINGLE (write the word)  
MARRIED MARRIED  
WIDOWED or DIVORCED10a If married, widowed, or divorced  
HUSBAND of ELLA MERRIAM  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 11 Months.....Days If under 24 hours  
.....Hours.....Minutes13 Usual Occupation: RETIRED  
(Kind of work done during most of working life)

14 Industry or Business: SEAMAN

15 Social Security No. 029-18-3654

16 BIRTHPLACE (City) TURKEY  
(State or country)

17 NAME OF FATHER NICHOLAS LENAS

18 BIRTHPLACE OF FATHER (City) TURKEY  
(State or country)

19 MAIDEN NAME OF MOTHER C/B/L

20 BIRTHPLACE OF MOTHER (City) C/B/L  
(State or country)21 Informant MRS. ELLA LENAS (WIFE)  
(Address) 21 DUNN RD. REVEREI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Joseph E. Sircann B.  
(Signature of Agent of Board of Health or other)Health Officer NOV 18 1964  
(Official Designation) (Date of Issue of Permit)



# EXTRACTS

FROM THE LAWS OF THE

## COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

### RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteenth, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

### SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

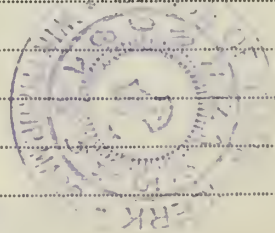
DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

NOV 3 1964 PM



# The Commonwealth of Massachusetts

JOSEPH D WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

To be filed for burial permit  
with Board of Health  
or its Agent.

Suffolk  
(County)

Winthrop  
(City or Town)

No. Cliff House 176 Cliff  
Nursing Home

## STANDARD CERTIFICATE OF DEATH

Registered No.

208

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

WW1

2 FULL NAME Ernest S. Ostburg  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 16 Bartlett St.  
(Usual place of abode)

St. Beverly, Mass.  
(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months — days. In place of residence 52 years — months — days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 18 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Sept 24, 1964, to Nov 18, 1964.  
I last saw him alive on Nov 18, 1964, death is said to  
have occurred on the date stated above, at 2:00 PM.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
1 year

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of prostate  
metastases

Due To  
(b)

Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No  
What test confirmed diagnosis? pathology report

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) H. B. G. 1024 12 12, M. D.

(Address) 447 (PRINT OR TYPE SIGNATURE)  
Date 11-18, 1964

6 Central Cemetery Beverly  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 20, 1964

7 NAME OF FUNERAL DIRECTOR Lee And Woody Co.  
ADDRESS 9 Dane St., Beverly, Mass.

Received and filed NOV 20 1964, 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
or DIVORCED

10a If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 years 10 months 8 days  
If under 24 hours  
Hours Minutes

13 Usual Occupation: Fisherman  
(Kind of work done during most of working life)

14 Industry or Business: Self-Employed

15 Social Security No.

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER George Ostburg

18 BIRTHPLACE OF FATHER (City) Holliston  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Engla Sjoblad

20 BIRTHPLACE OF MOTHER (City) Holliston  
(State or country) Mass.

21 Informant Carl E. Jacobson  
(Address) 10 Middle St., Beverly, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Jacobson  
(Signature of Agent of Board of Health or other)  
Health Officer Nov 19, 1964  
(Official Designation) (Date of Issue of Permit)



# SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....April 28 1918.....

DATE OF DISCHARGE.....April 17 1919.....

RANK, RATING .....Private.....

ORGANIZATION AND OUTFIT.....U. S. Army.....

SERVICE NUMBER.....2 720 408.....

## RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

NOV 2 1918 14





**EXTRACTS**  
FROM THE LAWS OF THE  
**COMMONWEALTH OF MASSACHUSETTS**  
GOVERNING THE  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION**

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



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Winthrop, Mass.

(City or Town)

PLACE OF DEATH

No. Winthrop Community Hospital

A/R/A (GENOEFFA) Genovetta

2 FULL NAME Martucci, Genevieve (Sarno)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 64 Lantern Rd. Revere, Mass.

(Usual place of abode)

1/2 Day

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence. 1 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 21 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY That I attended deceased from June 1964 to Nov 21 1964

I last saw him alive on Nov 21 1964 death is said to

have occurred on the date stated above, at 5:40 PM

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease yrs

Due To (b) Arteriosclerosis - Gen yrs.

Due To (c) Disease yrs.

OTHER SIGNIFICANT CONDITIONS I. Rheumatic Heart yrs.  
2. Congestive Failure WEEKS

Was autopsy performed?

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Joseph Gregorie M.D.

(Print or Type Name)

(Address) 194 Washington St. II/21 64

6 St Michael Boston  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 25 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 47 Winthrop St Winthrop

Received and filed NOV 27 1964 19

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD

## CERTIFICATE OF DEATH

Registered No. 210

{If death occurred in a hospital or institution, St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR) No

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

Female White MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Antonio Martucci  
(Husband's name in full)

12

AGE 69 Years 3 Month 13 Days If under 24 hours

13 Usual

Occupation Housewife  
(Kind of work done during most of working life)

14 Industry

or Business

at home

15 Social Security No.

015-28-6665

16 BIRTHPLACE (City).

(State or country)

Italy

17 NAME OF

FATHER

David Sarno

18 BIRTHPLACE OF

FATHER (City).

(State or country)

Italy

19 MAIDEN NAME

OF MOTHER

Maria Ricca

20 BIRTHPLACE OF

MOTHER (City).

(State or country)

Italy

21 Informant

(Address)

Augustino Martucci  
18 Brookfield Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph B. Sarno (S)

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

Nov 27, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

NOV 27 1964 PM

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts  
JOSEPH D. WARD  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Lynn

(City or town making return)

COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Registered No. ....

211

Essex  
(County)

Lynn

(City or Town)

No. Lynn Hospital

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

2 FULL NAME Robert Masucci  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 94 Main  
(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 21, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
Sudden death, presumably coronary occlusion.

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

If accidental, was injury causally related to the death?

Where did Injury occur?  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?  
(Specify type of place)

Manner of Injury  
(How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edmund A. Jannino, M. D.

(Address) 181 N. Common St. Lynn 11/21/64

7 Winthrop Cem. Winthrop  
Place of Burial, or Cremation, (City or Town)

DATE OF BURIAL Nov. 24/64

8 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano  
ADDRESS 147 Winthrop St., Winthrop

Received and filed .....19.....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED or DIVORCED married

11a If married, widowed, or divorced HUSBAND of Dorothy Cavalieri  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 52 Years 5 Months - Days If under 24 hours Hours Minutes

14 Usual Occupation: Scheduler  
(Kind of work done during most of working life)

15 Industry or Business: Electronics

16 Social Security No. Boston Mass.

17 BIRTHPLACE (City) (State or country) Eliseo Masucci

18 NAME OF FATHER Italy  
19 BIRTHPLACE OF FATHER (City) (State or country)

20 MAIDEN NAME OF MOTHER Ella Astrella

21 BIRTHPLACE OF MOTHER (City) (State or country) Boston Mass.

22 Informant Dorothy Masucci  
(Address) 94 Main St., Winthrop, Mass.

A TRUE COPY  
ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Nov. 25/64

1964

as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

05

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

Registered No.

212

No. Winthrop Community Hospital (If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gertrude C. Shanahan (If deceased is a married, widowed or divorced woman, give also maiden name.)  
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. 11 Sturgis St., St. (City or town and State)  
(Usual place of abode)

Length of stay: In place of death, years, months, 21 days. In place of residence, 35 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV. 22, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1956, to 11/22/1964

I last saw him alive on 11/22/1964, death is said to have occurred on the date stated above, at 12:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hypertensive Arteriosclerosis 84 yrs.  
Heart Disease.

Due To

(b)

Due To

(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATHOTHER  
SIGNIFICANT  
CONDITIONS

Atrial Fibrillation 64 yrs.  
Acute Pulmonary Edema 6 hrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Charles Liberman, M. D.  
CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 11/22/1964

6 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 25, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed NOV 24 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED Married  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of George W. Shanahan  
(Husband's name in full)

12 AGE 69 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Housewife  
(Kind of work done during most of working life)

14 Industry or Business Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston Mass  
(State or country)

17 NAME OF FATHER David Harrigan

18 BIRTHPLACE OF FATHER (City) East Boston Mass  
(State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Fitzpatrick

20 BIRTHPLACE OF MOTHER (City) East Boston Mass  
(State or country)

21 Informant George W. Shanahan

(Address) 11 Sturgis St.,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph G. Liberman (Signature of Agent of Board of Health or other)

Health Officer Nov. 24, 1964  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

V.R. V

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

SUFFOLK

(County)

WINTHROP

(City or Town)



The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

213

En route to Winthrop Community Hospital St. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

2 FULL NAME RICHARD (First Name) FRATI (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 81 Main St., Winthrop St.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 24, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)

Fracture of skull. Cerebral  
laceration.

5 Accident, suicide, or homicide (specify) Accident.

Date and hour of injury November 24, 1964  
11:30 A.M. Yes.

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur? Winthrop, Massachusetts.  
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in  
public place? Sidewalk.

Manner of injury Pedestrian struck by  
motor car  
(How did injury occur?)

Nature of injury No.

While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

Michael A. Luongo, M.D.  
(Address) Boston (Print or Type Name)

Date 11/24 1964

7 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 28 1964

8 NAME OF FUNERAL DIRECTOR Ernest P. Bognie

ADDRESS 147 Winthrop St. Winthrop

Received and filed NOV 27 1964

A TRUE COPY ATTEST:

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male 10 COLOR white 11 SINGLE (write the word)  
MARRIED WIDOWED DIVORCED UNKNOWN  
Single

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

13 AGE 3 Years 10 Months 26 Days If under 24 hours  
Hours Minutes

14 Usual Occupation: (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) Salem  
(State or country) Mass

18 NAME OF FATHER James Frati

19 BIRTHPLACE OF FATHER (City) Winthrop  
(State or country) Mass

20 MAIDEN NAME OF MOTHER Pauline Lawrence

21 BIRTHPLACE OF MOTHER (City) Canton  
(State or country) Mass.

22 Informant (Address) James Frati  
81 Main St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serianini (Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

#### STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Winthrop

(City or Town making this return)

Suffolk

(County)

Winthrop

(City or Town)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 214

No. 52 Sargent Street

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)}

2 FULL NAME Lewis Milton Hollingsworth

(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN - IMPORTANT

{(Was deceased a  
U. S. War Veteran, *no*  
if so specify WAR)

(a) Residence. No. 52 Sargent Street

(Usual place of abode)

St. (If nonresident, give city or town and State)

Length of stay: In place of death 45 years months days. In place of residence 45 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 24 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1961, to Dec 24, 1964

I last saw him live on 11/17/1964, death is said to have occurred on the date stated above, at 2:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY Occlusion

Due To Arterio sclerotic

(b) Heart Disease

Due To

(c)

INTERVAL  
BETWEEN  
ONSET AND  
DEATH1 day  
3yrs.OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS Date 11/25/1964

6 Winthrop Cemetery Winthrop, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 27, 1964

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed NOV 27 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)

male white MARRIED married  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Mabel Keziah Baker  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 77 Years 5 Months 22 Days If under 24 hours  
Hours Minutes13 Usual Occupation: retired Insurance Broker  
(Kind of work done during most working life)

14 Industry or Business General Insurance

15 Social Security No. 025-26-1595

16 BIRTHPLACE (City) East Boston  
(State or country) Massachusetts

17 NAME OF FATHER Thomas Hollingsworth

18 BIRTHPLACE OF FATHER (City) England  
(State or country)

19 MAIDEN NAME OF MOTHER Annie Corns

20 BIRTHPLACE OF MOTHER (City) England  
(State or country)21 Informant Mrs. Lewis M. Hollingsworth  
(Address)

52 Sargent St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Alfred B. Marsh

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

NOV 27 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

NOV 27 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



## The Commonwealth of Massachusetts

JOSEPH D. WARD

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSCOPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

Milton

(City or town making return)

Registered No.

215

Norfolk

(County)

Milton

(City or Town)

No. 38 State

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME Sarah A. McCarthy

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a

{U. S. War Veteran,  
(if so specify WAR)

no

(a) Residence. No. 895 Shirley

(Usual place of abode)

St. Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death - years - months 14 days. In place of residence 40 years - months - days.

## MEDICAL CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

3 DATE OF DEATH November 24, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY that I have investigated the death  
of the person above-named and that the CAUSE AND MANNER thereof  
are as follows: (If an injury was involved, state fully.)Presumably Coronary Sclerosis  
Died Suddenly

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

If accidental, was injury causally related to the death?

Where did  
injury occur? (City or town and State)Did injury occur in or about home, on farm, in industrial place, or in  
public place? (Specify type of place)Manner of  
injury (How did injury occur?)Nature of  
injury

While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Frederic Tudor M. D.

(Address) Milton, Mass. Date 11-25-64

7 Winthrop Cemetery Winthrop  
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL November 27, 1964

8 NAME OF FUNERAL DIRECTOR Maurice Kirby

ADDRESS 210 Winthrop St., Winthrop

Received and filed DEC 3 1964 19

(Registrar of City or Town where deceased resided)

9 SEX

10 COLOR

11 SINGLE (write the word)

MARRIED

WIDOWED

OR DIVORCED

Female

White

Widowed

11a If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of Michael McCarthy

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE 84 Years - Months - Days

If under 24 hours

Hours Minutes

14 Usual

Occupation:

Homemaker

(Kind of work done during most of working life)

15 Industry

or Business:

16 Social Security No.

17 BIRTHPLACE (City)

(State or country)

Boston

Mass.

18 NAME OF FATHER

C.N.B.L.

Doherty

19 BIRTHPLACE OF

FATHER (City)

(State or country)

Boston

Mass.

20 MAIDEN NAME

OF MOTHER

C.N.B.L. Crowley

21 BIRTHPLACE OF

MOTHER (City)

(State or country)

Boston

Mass.

22

Informant

(Address)

Cyril McCarthy

75 Harvard Street, Quincy

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

November 24, 1964

RECEIVED



DEC 3 1964 AM

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

# The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

## STANDARD

### CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No. **216**

PLACE OF DEATH

*Suffolk*  
(County)

*WINTHROP*  
(City or Town)

No. *CLIFF House Nursing Home* St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME *SAMUEL STEPNER*  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) *NO*

(a) Residence. No. *16 DANA* St. *Revere*  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death *10* years *10* months *10* days. In place of residence *16* years *10* months *10* days.

#### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH *Nov. 27 1964*  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
*Nov. 20 1964* to *Nov. 27 1964*  
I last saw him alive on *Nov. 26 1964*, death is said to  
have occurred on the date stated above, at *7:30 A.M.*

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) *Carcinomatosis*

Due To *Cancer of Prostate*  
(b)

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS *None*

Was autopsy performed? *No*  
What test confirmed diagnosis? *Clinical pathological*

5 Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify

(Signed) *Charles Luberman* M. D.

(Address) *WINTHROP, MASS.* Date *11/27/1964*

6 *Tifereth Israel - Everett*  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL *Nov 29 1964*

7 NAME OF FUNERAL DIRECTOR *TERR Funeral Service Inc*

ADDRESS *151 Washington Ave Chelsea*

Received and filed *NOV 27 1964*

(Registrar)

#### PERSONAL AND STATISTICAL PARTICULARS

8 SEX *M* 9 COLOR *W* 10 SINGLE (write the word)  
MARRIED *MARRIED*  
WIDOWED *MARRIED*  
or DIVORCED

10a If married, widowed, or divorced *ROSE BRAUN*  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE *72 (72 years)* or If under 24 hours  
Years Months Days Hours Minutes

13 Usual Occupation *Retired News Dealer*  
(Kind of work done during most of working life)

14 Industry or Business *Record American*

15 Social Security No. *010-07-9561*

16 BIRTHPLACE (City) *Russia*  
(State or country)

17 NAME OF FATHER *Barnet STEPNER*

18 BIRTHPLACE OF FATHER (City) *Russia*  
(State or country)

19 MAIDEN NAME OF MOTHER *LENA CBL*

20 BIRTHPLACE OF MOTHER (City) *Russia*  
(State or country)

21 Informant *GERALD STEPNER*  
(Address) *16 DANA St Revere*

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

*Ralph E. Sullivan* (Signature of Agent of Board of Health or other)

*Health Officer* (Official Designation) *Nov 27, 1964* (Date of Issue of Permit)



## EXTRACTS

FROM THE LAWS OF THE

### COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

## RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteenth, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhumate a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.

. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

## RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Danvers  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 217

PLACE OF DEATH

Essex  
(County)

Danvers  
(City or Town)

No. Danvers State Hospital, Hathorne, Mass.  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Weinstein  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Permanent Residence. No. 42 Pearl Street, Danvers, Mass.  
(Usual place of abode)

(City or town and State)

Length of stay: In place of death 4 years, 1 month, 20 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 14, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 30, 1961, to October 14, 1964.  
I last saw him alive on October 14, 1964, death is said to have occurred on the date stated above, at 2:20 p.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
Days

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Due To Sclerosis Months

(c) Due To Arteriosclerotic At Dis. Years

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) William H. Hausman, M. D.  
William H. Hausman

(Address) Hathorne, Mass. Date 10/14/64

6 Chaim Tefila, West Roxbury, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 15, 1964

7 NAME OF FUNERAL DIRECTOR Solomon Funeral Home

ADDRESS Brookline, Mass.

Received and filed 10/16/64 DEC 18 1964

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Fannie Florent  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 33 Years 3 Months 2 Days If under 24 hours  
Hours Minutes

13 Usual Occupation: Retired Liner Maker  
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 1-33-2-5743

16 BIRTHPLACE (City) Danvers, Mass.  
(State or country)

17 NAME OF FATHER Solomon Weinstein

18 BIRTHPLACE OF FATHER (City) Unknown  
(State or country) Russia

19 MAIDEN NAME OF MOTHER Rachel Greenoff

20 BIRTHPLACE OF MOTHER (City) Unknown  
(State or country) Russia

21 Informant Helen A. Polkowski

(Address) Danvers, Mass.

A TRUE COPY

ATTEST: Tracy I. Flannery  
(Registrar of City or Town where death occurred)

Dir. of Public Health 10/14/64  
DATE FILED 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

DEC 1 1964



KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Chelsea  
(City or Town making this return)

COPY OF  
CERTIFICATE OF DEATH

Registered No. 628

No. Chelsea Memorial Hospital (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME Arthur Joseph Larivee  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence, No. 265 Court Road  
(Usual place of abode) Winthrop, Mass. (City or town and State)

Length of stay: In place of death years months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 3, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
Apr. 23, 1964, to Nov. 3, 1964  
I last saw him alive on Nov. 3, 1964, death is said to  
have occurred on the date stated above, at 3:22 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Chronic myocarditis 7 mos.  
(b) Due To  
(c) Coronary artery disease 7 mos.

OTHER SIGNIFICANT CONDITIONS Chronic pulmonary emphysema 2 yrs.

Was autopsy performed? no  
What test confirmed diagnosis? Chest x-rays, EKG  
5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Thomas F. Wallace, M. D.

(Address) 251 Beach St., Revere 11/5/64

6 Holy Cross, Malden, Mass. (City or Town)

DATE OF BURIAL Nov. 7, 1964

7 NAME OF FUNERAL DIRECTOR Murray & Murray Inc.

ADDRESS 262 Beach St., Revere, Mass.

Received and filed DEC 23 1964

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN Married

11 If married, widowed, or divorced  
HUSBAND of Alice K. Coleman  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 74 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Supervisor  
(Kind of work done during most of working life)

14 Industry or Business Real Estate

15 Social Security No. 034-03-5160

16 BIRTHPLACE (City) Danvers  
(State or country)

17 NAME OF FATHER Peter Larivee

18 BIRTHPLACE OF FATHER (City) Holyoke, Mass.  
(State or country)

19 MAIDEN NAME OF MOTHER Amelia Boliveau

20 BIRTHPLACE OF MOTHER (City) Vermont  
(State or country)

21 Informant Mrs. Thomas Wallace

(Address) 251 Beach St., Revere, Mass.

A TRUE COPY Joseph A. Tyrrell

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED Nov. 6, 1964

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

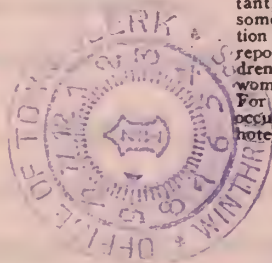
(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RECEIVED



DEC 23 1911



## OUT - OF - TOWN

The Commonwealth of Massachusetts

219

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSBoston  
(City or Town making this return)

## STANDARD

## CERTIFICATE OF DEATH

Registered No. 10823

PLACE OF DEATH

Suffolk -  
(County)Boston 20  
(City or Town)No. New England Baptist Hospital, St. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
Lena

## PHYSICIAN - IMPORTANT

2 FULL NAME Miss Lois L. King  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
(Was deceased a U. S. War Veteran, if so specify WAR) NO.(a) Permanent Residence. No. 53 Loring Road, St. Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death. years. 1 months. 1 days. In place of residence. years. months. days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 8 - 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from October 8, 1964, to November 8, 1964  
I last saw her alive on November 7, 1964, death is said to have occurred on the date stated above, at 3:15 AM.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBROVASCULAR HEMORRHAGE

(b) Due To ARTERIO SCLEROSIS

(c) Due To -

## OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO  
If so, specify

(Signature) Robert J. MacMillan M.D.

519 LONGWOOD AVE (Print or Type Name)  
(Address) BOSTON Date 8 NOV 19646 Winthrop Cemetery, Winthrop, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 11, 1964 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed NOV 13 1964 19

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX female 9 COLOR white 10 SINGLE (write the word) MARRIED single WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 68 Years 8 Months 11 Days 11 under 24 hours Hours Minutes

13 Usual Occupation clerk  
(Kind of work done during most of working life)

14 Industry or Business State St. Bank &amp; Trust

15 Social Security No. 020-12-2392

16 BIRTHPLACE (City) Newton  
(State or country) Massachusetts

17 NAME OF FATHER Frederick W. King

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country)

19 MAIDEN NAME OF MOTHER Emily Douglas

20 BIRTHPLACE OF MOTHER (City) Prince Edward Island  
(State or country)21 Informant Albert F. Lyon  
(Address) 20 Chapel St. Brookline


I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. J. Cogswell  
(Signature of Agent of Board of Health or other)04925 Nov 10, 1964  
(Official Designation) (Date of Issue of Permit)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



DEC 21 1964 AM

X  
PLACE OF DEATH

SUFFOLK

(County)  
BOSTON

(City or Town)

Massachusetts General Hospital

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

ELIZABETH

PAOLINI

2 FULL NAME

(First Name)

(Middle Name)

(Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

19 Wilshire Street,

Winthrop, Mass.

(a) Permanent Residence. No.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death...years...months...days. In place of residence...years...months...days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 10, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
Glutethimide poisoning. Diabetes mellitus. Cerebro-vascular disease.

5 Accident, suicide, or homicide (specify) Suicide.  
Date and hour of injury November 9, 1964

IF ACCIDENTAL, was injury causally related to the death?  
Where did injury occur? Winthrop, Mass.

(City or town and State)  
Did injury occur in or about home, on farm, in industrial place, or in public place? Home.  
Manner of Injury Ingestion of massive amount of Doriden.  
(How did injury occur?)

Nature of Injury Yes.  
While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

7 (Signed) Michael A. Laongo, M.D.  
Boston (Print or Type Name) 11/10 64  
(Address) Date 19...

8 Winthrop Cemetery Winthrop  
Place of Burial or Cremation (City or Town)  
DATE OF BURIAL Nov. 13 1964

9 Vincent R. Kapino  
NAME OF FUNERAL DIRECTOR  
ADDRESS Chelsea St., East Boston, Mass.

Received and Read NOV 25 1964  
A TRUE COPY ATTEST: (Registrar)

The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS



MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

11319

PHYSICIAN — IMPORTANT

((Was deceased a U. S. War Veteran, if so specify WAR) no

PERSONAL AND STATISTICAL PARTICULARS

9 SEX female 10 COLOR white 11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full) Vincenzo Paolini  
(Husband's name in full)

13 AGE 71 Years Months Days If under 24 hours, Hours Minutes

14 Usual Occupation: Housewife (Kind of work done during most of working life)

15 Industry or Business: at home

16 Social Security No. none

17 BIRTHPLACE (City) Italy (State or country)

18 NAME OF FATHER Frank Recchia

19 BIRTHPLACE OF FATHER (City) Italy (State or country)

20 MAIDEN NAME OF MOTHER Serafina Sancinello

21 BIRTHPLACE OF MOTHER (City) Italy (State or country)

22 Informant (Address) Donato Paolini (son)

19 Wilshire St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Signature of Agent of Board of Health or other

04953 Nov. 12, 1964

(Official Designation) (Date of Issue of Permit)

COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 21 1964 AM



R-301

trial permit  
Health  
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Suffolk

(County)

Boston

(City or Town)

New England Deaconess Hospital

No.

Mr. Hyman Housman

2 FULL NAME (If deceased is a married, widowed or divorced woman, give also maiden name.)

19 Wave Way Ave.

Winthrop, Mass.

(a) Permanent Residence. No.  
(Usual place of abode)

St.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 15, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Nov. 7, 1964, to November 15, 1964.

I last saw him alive on November 15, 1964, death is said to have occurred on the date stated above, at 8:15 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) INTERNAL CAROTID ARTERY  
THROMBOSIS WITH CORONARY

(b) INFARCTION

(c) COREBRAL ARTERIO - 4 YEARS  
SCLEROSIS

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS 9 YEARS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Donald M. Barnett M. D.

DONALD M. BARNETT

(Address) NEW ENGLAND DEACONESS HOSPITAL  
15 NOV. 64

6 Hand in Hand, West Roxbury

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL November 17, 1964

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed NO 8-1964

William J. Kane

(Registrar)

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

STANDARD

## CERTIFICATE OF DEATH

Registered No. 11016

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, WW1 if so specify WAR.)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

male

white

MARRIED

WIDOWED

DIVORCED

UNKNOWN

married

11 If married, widowed, or divorced HUSBAND of Rachel Pollock

(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12

AG 64

Years Months Days

If under 24 hours

Hours Minutes

13 Usual Occupation General Manager &amp; Salesman, Mfg.

(Kind of work done during most of working life)

14 Industry

or Business Radio

15 Social Security No. 021 20 7429

16 BIRTHPLACE (City) Boston, Mass.  
(State or country)

17 NAME OF

FATHER

Harris Housman

18 BIRTHPLACE OF

FATHER (City)

(State or country)

Hungary

19 MAIDEN NAME

OF MOTHER

Anna Markowitz

20 BIRTHPLACE OF

MOTHER (City)

(State or country)

Hungary

21 Informant

Lewis Housman

15 Roberta Road, Sharon, Mass.

(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Carter Ferranti

(Signature of Agent of Board of Health or other)

05-508

(Official Designation)

11-16-64

(Date of Issue of Permit)

A TRUE COPY ATTEST:

32 COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 21 1964

The Commonwealth of Massachusetts  
 KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

222

11085

SUFFOLK

(County)

BOSTON

(City or Town)

MEDICAL EXAMINER'S  
 CERTIFICATE OF DEATH

(City or Town making this return)

Registered No.

En route to East Boston Relief Station

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME EDWARD KIMBALL  
 (First Name) (Middle Name) (Last Name)  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
 (Was deceased a U. S. War Veteran, if so specify WAR) W.W.#1

(a) Permanent Residence. No. 87 Brewster Avenue, St. Winthrop, Massachusetts  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 15, 1964  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)  
 Coronary occlusion. Acute myocardial infarction.

5 Accident, suicide, or homicide (specify)

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did injury occur?  
 (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or public place?  
 (Specify type of place)

Manner of injury  
 (How did injury occur?)

Nature of injury  
 While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M.D.

(Address) Boston (Print or type name) Date 11/16 64

7 MT. Lebanon Cem. Iselin New Jersey  
 Place of Burial or Cremation. (City or Town)

DATE OF BURIAL November 19, 1964

8 NAME OF FUNERAL DIRECTOR Joseph P. Szulewski  
 ADDRESS 93 Otis St. Cambridge, Mass.

Received and filed 11-19-64

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX male 10 COLOR white 11 SINGLE (write the word) MARRIED widower  
 WIDOWED DIVORCED UNKNOWN

12 If married, widowed, or divorced HUSBAND of Frances J. Power  
 (Give maiden name of wife in full)

(or) WIFE of (husband's name in full)

13 AGE 64 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: Waiter  
 (Kind of work done during most of working life)

15 Industry or Business: Hotel

16 Social Security No. 124 09 6126

17 BIRTHPLACE (City) Austria  
 (State or country)

18 NAME OF FATHER Issaic Kimball

19 BIRTHPLACE OF FATHER (City) Austria  
 (State or country)

20 MAIDEN NAME OF MOTHER Esther Rosenhoch

21 BIRTHPLACE OF MOTHER (City) Austria  
 (State or country)

22 Informant Betty Garrett  
 Address 1320 W. Norwegian St. Pottsville PA.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

104395  
 (Official Designation)

11-19-64  
 (Date of Issue of Permit)

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-9-63-9363U8



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 5 1904

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

223

(City or Town making this return)

Suffolk

(County)

Boston

(City or Town)

STANDARD

## CERTIFICATE OF DEATH

Registered No. 11076

xx Veterans Administration Hospital

xx (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William E. Curry, Jr.

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, WWII if so specify WAR)

(a) Permanent Residence. No. 75 Bay View Ave.  
(Usual place of abode)

x Winthrop, Mass.

(City or town and State)

Length of stay: In place of death.....years.....4 months.....26 days. In place of residence.....years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 16 -- 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from June 23, 1964, to Nov. 16, 1964.

death is said to

have occurred on the date stated above, at 1:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Organizing bronchopneumonia

Due To Brain tumor

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify

(Signature) Robert H. North, M. D.

Robert North

(Print or Type Name)

(Address) VAH, Boston, Mass. Date Nov. 16, 1964

Holy Hood Cem., Brookline, Mass.

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 20, 1964 xx

7 NAME OF FUNERAL DIRECTOR Richard Kirby Inc.

ADDRESS 917 Bennington St. E. Boston, Mass.

Received and filed NOV 18 1964

19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced HUSBAND of Mary Fitzpatrick  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 54 Years 1 Months 5 Days If under 24 hours Hours.....Minutes

13 Usual Occupation Research Administrator  
(Kind of work done during most of working life)

14 Industry or Business Research

15 Social Security No. 029-05-7527

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER William E. Curry, Sr.

18 BIRTHPLACE OF FATHER (City) Boston  
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary Griffin

20 BIRTHPLACE OF MOTHER (City) Boston  
(State or country) Mass.

21 Informant V. A. Hospital Records, 150 S. Huntington Ave., Boston, Mass.  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter Ferranti  
(Signature of Agent of Board of Health or other)

05537  
(Official Designation)

Nov. 17, 1964  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar





R-301

SUFFOLK

(County)

BOSTON

(City or Town)


 KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

(City or Town making this return)

 STANDARD  
 CERTIFICATE OF DEATH

Registered No. 11192

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPOUNANT

2 FULL NAME Charles G. Huby

(If deceased is a married, widowed or divorced woman, give also maiden name.)

 (Was deceased a No  
 U. S. War Veteran,  
 if so specify WAR.)

 (a) Permanent Residence. No. Sturgis Street  
 (Usual place of abode)

Winthrop, Mass.

(City or town and State)

Length of stay: In place of death years 6 months 6 days. In place of residence 2 years months days.

## MEDICAL CERTIFICATE OF DEATH

 3 DATE OF DEATH November 19 1964  
 (Month) (Day) (Year)

 4 I HEREBY CERTIFY, That I attended deceased from  
 November 13, 19 64 to November 19, 19 64  
 I last saw him alive on November 19, 19 64, death is said to  
 have occurred on the date stated above, at 12:05 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

 (a) Pulmonary Edema and Congestive  
 Heart Failure Weeks

Due To (b) Coronary Artery Disease Years

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

 5 Was disease or injury in any way related to occupation of deceased?  
 If so, specify

(Signature) Charles L. Cloy, M.D.

 (Print or Type Name)  
 Charles L. Cloy, M.D.

(Address) Asst. Dir., Mass. Gen'l. Hosp. Date Nov. 19, 19 64

 6 Winthrop Winthrop  
 Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 21, 19 64

 7 NAME OF FUNERAL DIRECTOR Howard S Reynolds  
 Winthrop Mass

 ADDRESS  
 NOV 24 1964

 Received and filed  
 William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

 8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
 MARRIED  
 WIDOWED  
 DIVORCED  
 UNKNOWN Widowed

 11 If married, widowed, or divorced  
 HUSBAND of Edith Maddick  
 (Give maiden name of wife in full)

 (or) WIFE of  
 (Husband's name in full)

 12 AGE 87 Years 5 Months 7 Days If under 24 hours  
 Hours Minutes

 13 Usual Occupation Chauffeur  
 (Kind of work done during most of working life)

14 Industry or Business Private

15 Social Security No 010-07-4167

 16 BIRTHPLACE (City) Hull  
 (State or country) England

17 NAME OF FATHER Richard Huby

 18 BIRTHPLACE OF FATHER (City)  
 (State or country) England

19 MAIDEN NAME OF MOTHER Martha Goodall

 20 BIRTHPLACE OF MOTHER (City)  
 (State or country) England

 21 Informant Dorothy Fearing  
 (Address) 53 Taft Ave. Winthrop

 I HEREBY CERTIFY that a satisfactory standard certificate of death  
 was filed with me BEFORE the burial or transit permit was issued  
 Walter Ferranti  
 (Signature of Agent of Board of Health or other)  
 05572 11-20-64  
 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 11 1904 'V'

OUT - OF - TOWN

SUFFOLK

(County)

BOSTON

(City or Town)

KEVIN H. WHITE  
 SECRETARY OF THE COMMONWEALTH  
 DIVISION OF VITAL STATISTICS

Boston

(City or Town making this return)

STANDARD  
 CERTIFICATE OF DEATH

Registered No. 11331

No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number)

E.

PHYSICIAN — IMPORTANT

2 FULL NAME Clara Hyde (Spinney)  
 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
 U. S. War Veteran,  
 if so specify WAR)

NO.

(a) Permanent Residence. No. 235 Washington Avenue St. Winthrop Mass.  
 (Usual place of abode) (City or town and State)

Length of stay: In place of death.....years.....months.....5days. In place of residence. 45years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 22 1964  
 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
November 17, 64 to November 22, 64  
 I last saw her alive on November 22, 1964 death is said to  
 have occurred on the date stated above, at 3:45A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Fractured Right Hip

INTERVAL  
 BETWEEN  
 ONSET AND  
 DEATH  
5 days

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT  
 CONDITIONS Mild Paralytic Ileus

Was autopsy performed? NoWhat test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?  
 If so, specify no

(Signature) Charles L. Clay, M.D. M. D.

(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Nov. 22 19646 Winthrop Cemetery Winthrop, Mass

Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 24 1964

7 NAME OF FUNERAL DIRECTOR

Alfred B. MarshADDRESS 174 Winthrop St. Winthrop, MassReceived and filed NOV 30 1964William J. Kane

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)  
 MARRIED married  
 WIDOWED  
 DIVORCED  
 UNKNOWN

female white

11 If married, widowed, or divorced

HUSBAND of

(Give maiden name of wife in full)

(or) WIFE of George W. Hyde

(Husband's name in full)

12

AGE 77 Years 3 Months 27 Days

If under 24 hours

Hours Minutes

13 Usual

Occupation housewife

(Kind of work done during most of working life)

14 Industry

or Business.

own home

15 Social Security No.

none

16 BIRTHPLACE (City)

(State or country)

Lynn Mass.

17 NAME OF

FATHER

Herbert A. Spinney

18 BIRTHPLACE OF

FATHER (City)

Lynn

(State or country)

Mass.

19 MAIDEN NAME

OF MOTHER

Jennie M. ?

20 BIRTHPLACE OF

MOTHER (City)

Lynn

(State or country)

Mass.

21 Informant

George W. Hyde

(Address)

235 Washington Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
 was filed with me BEFORE the burial or transit permit was issued:

William J. Kane  
 (Signature of Agent of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

Jurisdiction Declined By Medical Examiner



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 27 1894

For burial permit  
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PLACE OF DEATH

SUFFOLK

(County)

DORCHESTER

(City or Town)

No. CARNEY Hosp.

2 FULL NAME Joseph Pagliarulo

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No.

(Usual place of abode)

41 SEWALL AVE

St. WINTHROP, MASS.

(City or town and State)

Length of stay: In place of death.....years.....months.....21 days. In place of residence 20 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH NOV 22 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from 11-1-64, 19....., to 11-22, 1964.

I last saw him alive on 11-22, 1964 death is said to have occurred on the date stated above, at 4:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIAC FAILURE

Due To C.V.A.

Due To Carcinoma of Bowel - rectal 1 yr. ago.

OTHER SIGNIFICANT CONDITIONS Extensive Pulmonary Metastasis

Was autopsy performed? NO

What test confirmed diagnosis? NO pulse, no resp., no heart beat

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Angelo Lombusso, M. D.

ANGELO LOMBUSSO

(Print or Type Name)

(Address) 15 PARK ST. Bldg. Date 11-22 1964

MASS.

6 Winthrop Cemetery Winthrop Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 25 1964

7 NAME OF FUNERAL DIRECTOR Edmond Mitchell. Dooley Funeral Home

ADDRESS 135 London St. East Boston.

Received and filed NOV 25 1964

William J. Kane

(Registrar)

A TRUE COPY ATTEST:

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 11313

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{ (Was deceased a  
U. S. War Veteran, No  
if so specify WAR)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED Married  
WIDOWED  
DIVORCED  
UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Caroline Silva  
(Give maiden name of wife in full)

(or) WIFE of.....  
(Husband's name in full)

12 AGE 62 Years..... Months..... Days.....  
11 under 24 hours Hours..... Minutes

13 Usual Occupation Fruit Broker  
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 022 01 9257

16 BIRTHPLACE (City) Boston  
(State or country) Mass.

17 NAME OF FATHER Emileo Pagliarulo

18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

19 MAIDEN NAME OF MOTHER Philomenia Staffieri

20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

21 Informant Caroline Pagliarulo  
41 Sewall Ave. Winthrop  
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death  
has been filed with the RECORDS the burial or transit permit was issued:

Cooper Ferrante  
(Signature of Agent of Board of Health or other)

05626 11-23-64  
(Official Designation) (Date of Issue of Permit)

V.B.V.

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

DEC 27 1874



PLACE OF DEATH

SUFFOLK

(County)  
BOSTON

(City or Town)

The Commonwealth of Massachusetts  
KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

227

(City or Town making this return)

11456

Registered No.

MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

En route to Massachusetts General Hospital

No. \_\_\_\_\_ St. { give its NAME instead of street and number)

VINCENT

McLEAN

2 FULL NAME (First Name) (Middle Name) (Last Name)  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

45 Beacon Street,

Winthrop, Mass.

(a) Permanent Residence. No. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days. In place of residence \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 27, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary artery disease. Acute myocardial infarction.

5 Accident, suicide, or homicide (specify) \_\_\_\_\_

Date and hour of injury \_\_\_\_\_ 19 \_\_\_\_\_

IF ACCIDENTAL, was injury causally related to the death? \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town and State)Did injury occur in or about home, on farm, in industrial place, or in public place? \_\_\_\_\_  
(Specify type of place)Manner of injury \_\_\_\_\_  
(How did injury occur?)Nature of injury \_\_\_\_\_  
While at work? \_\_\_\_\_ Was employ performed? No.

6 Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_  
(Signed) Michael R. Luongo, M.D.

(Address) Boston (Print or Type Name) Date 11/27 64

7 PLACE OF BURIAL OR CREMATION Winthrop (City or Town)

DATE OF BURIAL NOV 30 1964

8 NAME OF FUNERAL DIRECTOR MARILEE W. KIRBY

ADDRESS Winthrop

Received and filed DEC 3 1964

A TRUE COPY ATTEST: (Regist.)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX 10 COLOR 11 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN MARRIED12 If married, widowed, or divorced  
HUSBAND of MARGARET E. SCHULTZ  
(Give maiden name of wife in full)(or) WIFE of \_\_\_\_\_  
(Husband's name in full)13 AGE 34 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If under 24 hours \_\_\_\_\_ Hours \_\_\_\_\_ Minutes14 Usual Occupation: \_\_\_\_\_  
(Kind of work done during most of working life)

15 Industry or Business: RETAIL MDS

16 Social Security No. \_\_\_\_\_

17 BIRTHPLACE (City) PROVIDENCE  
(State or country) R.I.18 NAME OF FATHER ALEXANDER  
FATHER J McLEAN19 BIRTHPLACE OF FATHER (City) CANADA  
(State or country)

20 MAIDEN NAME OF MOTHER ANNA CAFFERTY

21 BIRTHPLACE OF MOTHER (City) IRELAND  
(State or country)22 Informant (Address) MARGARET McLEAN  
45 BEACON ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

F. P. Grace CO5115  
(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

V. B.

A TRUE COPY ATTEST:

*William J. Kane.*  
City Register

DEC 24 1984

1. burial permit  
of Board of Health  
Agent.

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk  
(County)

Winthrop  
(City or Town)



## STANDARD CERTIFICATE OF DEATH

Registered No. 228

Cliff House Nursing Home

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie M (Abrams) White  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)

(a) Residence, No. 132 Grandview Ave.  
(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death years months 2 days. In place of residence years months days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DECEMBER 4, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
FEB. 12, 1955 to DEC. 4, 1964  
I last saw her alive on DEC. 4, 1964 death is said to  
have occurred on the date stated above, at 1:40 P.M.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic + Hypertensive Heart Disease 9 YRS  
Due To Generalized Arteriosclerosis 12 YRS  
(b)

Due To  
(c)

OTHER SIGNIFICANT CONDITIONS Pernicious Anemia 7 YRS

Was autopsy performed? No.

What test confirmed diagnosis? Clinical + Laboratory.

5 Was disease or injury in any way related to occupation of deceased? No.  
If so, specify

(Signature) M. Traumbstein M. D.

M. TRAUMBSTEIN, JR. M.D.  
(Print or Type Name)

(Address) 73 Bartlett Rd, Winthrop, Mass. Dec. 4, 1964

6 Center Cemetery Bellingham, Mass.  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 7, 1964

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed DEC 7 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, wife HUSBAND of (Give maiden name of wife in full)

(or) WIFE of Carroll F White (Husband's name in full)

12 AGE 77 Years 8 Months 7 Days If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 023-14-0453

16 BIRTHPLACE (City) Pottstown (State or country) Penn.

17 NAME OF FATHER Frederick Abrams

18 BIRTHPLACE OF FATHER (City) (State or country) Germany

19 MAIDEN NAME OF MOTHER Henerietta

20 BIRTHPLACE OF MOTHER (City) (State or country) Germany

21 Informant Carroll White (Address) 132 Grandview Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Health Officer (Signature of Agent of Board of Health or other) Dec 7 1964 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

DEC - 7 1964 AM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)



## The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

## STANDARD

## CERTIFICATE OF DEATH

To be filed for burial permit  
with Board of Health  
or its Agent.

Registered No.

229

No. Cliff House Nursing HomeSt. (If death occurred in a hospital or institution,  
give its NAME instead of street and number)2 FULL NAME Frank L. Gross

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR)(a) Residence. No. Stonington

(Usual place of abode)

St. Maine

(If nonresident, give city or town and State)

Length of stay: In place of death 2 years 2 months 4 days. In place of residence 5 years 0 months 0 days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 10-4 (Month) 1964 (Day) 1964 (Year)

4 I HEREBY CERTIFY, That I attended deceased from

10-4, 1964, to Dec 6, 1964I last saw him alive on Dec 1, 1964, death is said tohave occurred on the date stated above, at 4:30 P m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of lung

Due To (b)

2 mos

Due To (c)

OTHER  
SIGNIFICANT  
CONDITIONSDuodenal ulcerWas autopsy performed? NOWhat test confirmed diagnosis? X-Rays

5 Was disease or injury in any way related to occupation of deceased?

If so, specify NO(Signed) H. J. Greenfield, M. D.(Address) 447 Shirley St, Winthrop, Me Date Dec 6, 19646 Mount Rest Stonington Maine

Place of Burial or Cremation

(City or Town)

DATE OF BURIAL December 10, 19647 NAME OF FUNERAL DIRECTOR Bragdon Funeral Home207 Main St, Ellsworth, Me

ADDRESS

Received and filed DEC 9 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED Widowed

Male

White

10a If married, widowed, or divorced

HUSBAND of Carrie Mae Farmer

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE 80 Years 7 Months 20 Days

If under 24 hours

Hours Minutes

13

Usual Occupation: Retired Lobsterman

(Kind of work done during most of working life)

14

Industry or Business: Fishing

15

Social Security No. Stonington

16

BIRTHPLACE (City) Maine

(State or country)

17

NAME OF FATHER Swanzy Gross

18

BIRTHPLACE OF

FATHER (City)

(State or country) Maine

19

MAIDEN NAME

OF MOTHER

Emily Rich

20

BIRTHPLACE OF

MOTHER (City)

(State or country) Maine

21

Informant Mrs Pearl Browning(Address) 36 Grandview, WinthropI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:Ralph E. Serianis (ack)

(Signature of Agent of Board of Health or other)

Health Officer

(Official Designation)

12/8/64

(Date of Issue of Permit)

**EXTRACTS**  
FROM THE LAWS OF THE  
**COMMONWEALTH OF MASSACHUSETTS**  
GOVERNING THE  
**RETURN OF CERTIFICATES OF DEATH**

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the Chinese relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original, interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

EC - 11064 AM

**RULES OF PRACTICE**

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

- (1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.
- (2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.
- (3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

**SPACE FOR ADDITIONAL INFORMATION**

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

SERVICE NUMBER



## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATHRegistered No. **230**

**PLACE OF DEATH**  
1 **SUFFOLK**  
(County)  
**WINTHROP**  
(City or Town)

No. **45 HILLSIDE AVE.**(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)**PHYSICIAN — IMPORTANT**

2 FULL NAME **JENNIE PITTS (FRAZIER)**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)  
**41-H.**

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) **NO**

(a) Permanent Residence. No. **45 HILLSIDE AVE** St. **WINTHROP**  
(Usual place of abode) (City or town and State)

Length of stay: In place of death **35** years.....months.....days. In place of residence **35** years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 7, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Feb. 8, 1952, to Dec. 7, 1964**

I last saw him alive on **Dec. 6, 1964** death is said tohave occurred on the date stated above, at **7:30 am.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

**Arteriosclerotic and hyper**  
(a) **tensive heart disease**

(b) Due To **Generalized**  
**Arteriosclerosis**

(c) Due To  
(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? **no**What test confirmed diagnosis **Clinical & laboratory**

5 Was disease or injury in any way related to occupation of deceased **No**  
If so, specify

(Signature) **M. Traunstein Jr.** M. D.**M. Traunstein, Jr., M.D.**(Address) **73 Bartlett Rd. Dec. 8, 1964****Winthrop, Mass. 02152**

6 **HOLY CROSS** **MALEDEN**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **DEC 10** 19**64**

7 NAME OF FUNERAL DIRECTOR **MARVIE WILBY**

ADDRESS **WINTHROP**  
**DEC 9 1964**

Received and filed .....19.....

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **FEMALE** 9 COLOR **WHITE** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **WIDOWED**

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of **WILLIAM J. PITTS**  
(Husband's name in full)

12 AGE **95** Years.....Months.....Days If under 24 hours  
.....Hours.....Minutes

13 Usual Occupation **HOME MAKER**  
(Kind of work done during most of working life)

14 Industry  
or Business **HOME**

15 Social Security No. **NONE**

16 BIRTHPLACE (City) **NOVA SCOTIA**  
(State or country)

17 NAME OF FATHER **(UNKNOWN) — FRAZIER**

18 BIRTHPLACE OF FATHER (City) **NOVA SCOTIA**  
(State or country)

19 MAIDEN NAME OF MOTHER **(UNKNOWN)**

20 BIRTHPLACE OF MOTHER (City) **NOVA SCOTIA**  
(State or country)

21 Informant **MRS MARY MORAN**(Address) **45 HILLSIDE AVE WINTHROP**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Ralph E. Sirovanni (wk)**  
(Signature of Agent of Board of Health or other)

**Health Officer**  
(Official Designation)

**12-9-64**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....1

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....



DEC - 9 1964 PM

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)



Suffolk  
(County)

Winthrop  
(City or Town)

## STANDARD CERTIFICATE OF DEATH

Registered No. **231**

No. **Winthrop Community Hospital**

St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Baby Boy DeCoursey**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Permanent Residence. No. **22 Prescott Street**  
(Usual place of abode)

St. **Winthrop, Mass.**

(City or town and State)

Length of stay: In place of **2** years.....months.....**2** days. In place of residence.....years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Dec. 10, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from **12/9/64**, 19**64**, to **12/10**, 19**64**

I last saw him alive on **12/10**, 19**64** death is said to have occurred on the date stated above, at **2:40 P. M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **PREMATURITY**

INTERVAL BETWEEN ONSET AND DEATH

**36 hours**

Due To

(b)

Due To

(c)

OTHER SIGNIFICANT CONDITIONS

**None**

Was autopsy performed?

**No**

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) **William A. Glone**, M. D.

(Print or Type Name)

(Address) **190 Prescott St. Winthrop** **12/10/64**

6 **Winthrop Cemetery** **Winthrop**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 11, 1964**

7 NAME OF FUNERAL DIRECTOR **Richard C. Kirby Inc.**

ADDRESS **917 Bennington St. E. Boston**

Received and filed **DEC 11 1964**

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **M** 9 COLOR **White** 10 SINGLE (write the word)

**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **Single**

11 If married, widowed, or divorced

HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **1** Years.....Months.....**1** Days If under 24 hours  
Hours.....Minutes

13 Usual Occupation.....  
(Kind of work done during most of working life)

14 Industry or Business.....

15 Social Security No.....

16 BIRTHPLACE (City).....**Winthrop, Mass.**  
(State or country)

17 NAME OF FATHER **Richard DeCoursey**

18 BIRTHPLACE OF FATHER (City).....**Winthrop**  
(State or country) **Mass.**

19 MAIDEN NAME OF MOTHER **Jean A. Vienneau**

20 BIRTHPLACE OF MOTHER (City).....**Worcester**  
(State or country) **Mass.**

21 Informant **Mr. Richard DeCoursey**  
(Address) **22 Prescott St. Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

**Reph E. Brennan**

(Signature of Agent of Board of Health or other)

**Health Officer**  
(Official Designation)

**December 11, 1964**  
(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1301A

CERTIFICATE

DEATH

enter  
one  
each  
and (c)not mean  
dying,  
failure,  
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ion givenChapter 137,  
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to print or  
cause or  
death on  
ates.

100M-11-55-916145

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

Cliff House Nursing Home

No.

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

2 FULL NAME

Catherine (O'Hara) Romig

(If deceased is a married, widowed or divorced woman, give also maiden name.)

284 Main

(a) Residence. No.

(Usual place of abode)

St.

Winthrop, Mass.

(If nonresident, give city or town and State)

Length of stay: In place of death. - years. 1 months. 8 days. In place of residence. - years. 5 months. - days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF  
DEATH

December 10, 1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY, That I attended deceased from

Oct. 31, 1964 to Dec. 10, 1964

I last saw him alive on Dec. 9, 1964, death is said to

have occurred on the date stated above, at 4:05 a.m.

INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease

1 year.

Due To

(b) Generalized arteriosclerosis

5 years.

Due To

(c) ---

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical findings

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

John F. Collins, M. D.

(Address)

27 Pennington St., Revere

6

Holyhood, Brookline

Place of Burial or Cremation

December 12, 1964

7 NAME OF  
FUNERAL DIRECTOR

W. H. Thomas

ADDRESS

75 Galen st., Watertown.

Received and filed

DEC 11 1964

(Registrar)

## The Commonwealth of Massachusetts

EDWARD J. CRONIN

SECRETARY OF THE COMMONWEALTH

DIVISION OF VITAL STATISTICS

## STANDARD

## CERTIFICATE OF DEATH

Registered No.

232

PHYSICIAN — IMPORTANT

(Was deceased a

U. S. War Veteran,

if so specify WAR)

no

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX

9 COLOR

10 SINGLE (write the word)

female

white

MARRIED

WIDOWED

or DIVORCED

Widowed

10a If married, widowed, or divorced

HUSBAND of

William A. Romig

(or) WIFE of

(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12

AGE

77

Years

Months

Days

If under 24 hours

Hours Minutes

13 Usual

Housewife

Occupation:

(Kind of work done during most of working life)

14 Industry

or Business:

at home

NONE

15 Social Security No.

16 BIRTHPLACE (City)

(State or country)

Leitrim,

Ireland

17 NAME OF

FATHER

William O'Hara

18

BIRTHPLACE OF

FATHER (City)

(State or country)

Leitrim

Ireland

19

MAIDEN NAME

OF MOTHER

Mary O'Rourke

20

BIRTHPLACE OF

MOTHER (City)

(State or country)

Leitrim

Ireland

21

Informant

(Address)

Robert E. Romig (son)

284 Main st. Winthrop.

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Serrano (s.)

(Signature of Agent of Board of Health or other)

Health Officer

December 11, 1964

(Official Designation)

(Date of Issue of Permit)

## EXTRACTS

FROM THE LAWS OF THE

### COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

## RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourty-six, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the

death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given, and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

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No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held; or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

## RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE

DATE OF DISCHARGE

RANK, RATING

ORGANIZATION AND OUTFIT

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

SUFFOLK

(County)

WINTHROP

(City or Town)

STANDARD

## CERTIFICATE OF DEATH

Registered No. 233

No. WINTHROP COMMUNITY HOSPITAL

{(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME ELLEN CORBETT (McMANUS)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) No

(a) Permanent Residence. No. 25 PLUMMER AVENUE  
(Usual place of abode)

St. WINTHROP MASS.

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC 12 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 5/12, 1963, to DEC 12, 1964  
I last saw her alive on 12/12/64, death is said to have occurred on the date stated above, at 3:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CIRCUMSTANCES

INTERVAL  
BETWEEN  
ONSET AND  
DEATH  
6 Mo

Due To (b) ADENOCARCINOMA OF RECTUM 11/12/64

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No  
What test confirmed diagnosis? PATHOLOGY AT OPER.

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Guyon D. King, M. D.  
(Print or Type Name)

(Address) 22 PLEASANT ST. WINTHROP, MASS. 01890  
Date 12/12/64

6 WINTHROP WINTHROP  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec 16 1964

7 NAME OF FUNERAL DIRECTOR Ernest P. Pappano

ADDRESS 147 WINTHROP ST WINTHROP

Received and filed DEC 14 1964

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

11 If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of James H. Corbett (Husband's name in full)

12 AGE 57 Years 10 Months 24 Days If under 24 hours Hours Minutes

13 Usual Occupation Housewife (Kind of work done during most of working life)

14 Industry or Business at Home

15 Social Security No. 423-36-5124

16 BIRTHPLACE (City) Boston (State or country) Mass

17 NAME OF FATHER Francis E. McManus

18 BIRTHPLACE OF FATHER (City) Ohio (State or country)

19 MAIDEN NAME OF MOTHER Susan L. McCallpha

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

21 Informant James H. Corbett (Address) 25 Plummer Ave WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph G. Sullivan (Signature of Agent of Board of Health or other)

Health Officer Dec 14 1964 (Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

2 FULL NAME Carl H. Schleicher

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Permanent Residence. No. 660 Bennington St.

(Usual place of abode)

St. East Boston, Mass.

(City or town and State)

Length of stay: In place of death.....years.....months.....5 days. In place of residence 80 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 12 12 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from 12-5-1964 to 12-12-1964

I last saw him alive on 12-12-64, 1964, death is said to have occurred on the date stated above, at 2:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cerebral Vascular Accident

(b) Generalized Arterio-

(c) Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

7dys

20yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) John F. Papi M.D.

(Print or Type Name) JOHN F. PAPI M.D.

(Address) East Boston, Mass. Date 12-12-64

6 Woodlawn Cemetery, Everett, Mass.

Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 15th 1964

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed DEC 14 1964

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD

CERTIFICATE OF DEATH

Registered No. 234

{(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

{(Was deceased a U. S. War Veteran, if so specify WAR) NO

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED Divorced UNKNOWN

11 If married, widowed or divorced HUSBAND of Therese Spindler (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 96 Years. Months. Days If under 24 hours Hours Minutes

13 Usual Occupation Baker-retired (Kind of work done during most of working life)

14 Industry or Business Bakery-self employed

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Germany

17 NAME OF FATHER Henry Schleier

18 BIRTHPLACE OF FATHER (City) (State or country) Germany

19 MAIDEN NAME OF MOTHER Caroline Schilling

20 BIRTHPLACE OF MOTHER (City) (State or country) Germany

21 Informant Miss Charlotte R. Schleicher

(Address) 660 Bennington St., E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Loomis (3)

(Signature of Agent of Board of Health or other)

Health Officer

Dec. 14, 1964

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING ..... DEC 1 1964 PM  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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# The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

## STANDARD CERTIFICATE OF DEATH

Registered No. **235**

PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. **1 Coral Avenue**

(If death occurred in a hospital or institution,  
St. (give its NAME instead of street and number)

**PHYSICIAN — IMPORTANT**

2 FULL NAME **Daniel Krantz**

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, no  
if so specify WAR)

(a) Residence. No. **1 Coral Avenue**

(Usual place of abode)

St. (City or town and State)

Length of stay: In place of death **22** years.....months.....days. In place of residence **22** years.....months.....days.

### MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **Dec 13, 1964**  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
**Jan 50** 19**50** to **12/13/1964** 19**64**

I last saw him alive on **12/11/1964** death is said to  
have occurred on the date stated above, at **10:45 P.M.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Arteriosclerotic Heart Disease** **3yrs.**

Due To (b) **Arteriosclerosis, coronary** **3yrs.**

Due To (c)

OTHER SIGNIFICANT CONDITIONS **Pulmonary Emphysema 10yrs**  
**Ventral Hernia post op. 8yrs**

Was autopsy performed? **No**  
What test confirmed diagnosis? **Clinical**

5 Was disease or injury in any way related to occupation of deceased **No**  
If so, specify

(Signature) **Charles Liberman** M. D.  
**CHARLES LIBERMAN**

(Address) **WINTHROP, MASS.** Date **12/13/1964**

6 **Robury Mutual (Montvale) Woburn**  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL **December 15, 1964**

7 NAME OF FUNERAL DIRECTOR **Benjamin F. Solomon**

ADDRESS **420 Harvard Street, Brookline**

Received and filed **DEC 14 1964** 19

(Registrar)

### PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)  
**MARRIED**  
**WIDOWED**  
**DIVORCED**  
**UNKNOWN** **married**

11 If married, widowed, or divorced **Elsie Swart**  
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE **66** Years. Months. Days If under 24 hours  
Hours Minutes

13 Usual Occupation: **Driver**  
(Kind of work done during most of working life)

14 Industry or Business: **Taxi**

15 Social Security No.

16 BIRTHPLACE (City) (State or country) **Russia**

17 NAME OF FATHER **Boris Krantz**

18 BIRTHPLACE OF FATHER (City) (State or country) **Russia**

19 MAIDEN NAME OF MOTHER **Sophie Perlis**

20 BIRTHPLACE OF MOTHER (City) (State or country) **Russia**

21 Informant **Mrs. Daniel Krantz**

(Address) **1 Coral Avenue, Winthrop**

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

**Reph E. Brennan** (Signature of Agent of Board of Health or other)

**Health Officer** (Official Designation)

**Dec 14, 1964** (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING .....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATHRegistered No. **236**

PLACE OF DEATH

SUFFOLK  
(County)Winthrop  
(City or Town)

No. 56 Haldemar Ave

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)2 FULL NAME Charles E. Murphy  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran, No  
if so specify WAR)(a) Permanent Residence, No. 56 Haldemar Ave  
(Usual place of abode)St. Winthrop  
(City or town and State)

Length of stay: In place of death 70 years months days. In place of residence 70 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 15, 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
AUG 31, 1951 to DEC 15, 1964I last saw him live on 12/13, 1964 death is said to  
have occurred on the date stated above, at 330 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CEREBRAL VASCULAR ACCT

(b) Due To ARTERIO-SCLEROTIC  
HEARTDISEASE

(c) Due To GENERAL ARTERIO-SCLEROTIC

OTHER SIGNIFICANT CONDITIONS  
NEPHROSCLEROSIS  
HATUS HERNIA

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Myron N. King, M. D.

(Address) 322 Pleasant St. Winthrop 12-15-64

Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec. 17, 1964

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS 325 Chelsea St. East Boston

Received and filed DEC 17 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed or divorced  
HUSBAND of SARAH F. O'Keefe  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 89 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation TRUCKER  
(Kind of work done during most of working life)

14 Industry or Business Retired

15 Social Security No. 033-26-6399

16 BIRTHPLACE (City)  
(State or country) EAST BOSTON MASS.

17 NAME OF FATHER William Murphy

18 BIRTHPLACE OF FATHER (City) Boston  
(State or country) MASS.

19 MAIDEN NAME OF MOTHER Elizabeth Sparrow

20 BIRTHPLACE OF MOTHER (City) Haverhill  
(State or country) MASS.

21 Informant Helen A. Kincaid

(Address) 56 Haldemar Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Kathleen L. Lannan (2)

(Signature of Agent of Board of Health or other)  
Health Officer December 16, 1964

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING .....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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## The Commonwealth of Massachusetts

KEVIN H. WHITE

SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

Suffolk  
(County)

Winthrop  
(City or Town)



STANDARD  
CERTIFICATE OF DEATH

Registered No. 237

No. 8 Atlantic St.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Patrick F. Kirley

(If deceased is a married, widowed or divorced woman, give also maiden name.)

## PHYSICIAN — IMPORTANT

(Was deceased a  
U. S. War Veteran,  
if so specify WAR) WW 1

(a) Residence, No. 8 Atlantic St.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In place of death, 40 years, months, days. In place of residence, 40 years, months, days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 18, 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from  
19, to 19, 19.

I last saw h. alive on 19, death is said to  
have occurred on the date stated above, at 1:30 P.m.

## DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due  
(b) to natural causes

Due To Winthrop Board of Health  
(c)

OTHER SIGNIFICANT CONDITIONS Charles Liberman, M.D.

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

(Signature) Charles Liberman M. D.

CHARLES LIBERMAN

(Print or Type Name)

(Address) WINTHROP, MASS. Date 12/18/64

6 Winthrop Winthrop Mass  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 21, 1964

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed DEC 21 1964 19.

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED WIDOWED Widowed  
DIVORCED UNKNOWN

11 If married, widowed, or divorced  
HUSBAND of Hazel Cody  
(Give maiden name of wife in full)

(or) WIFE of  
(Husband's name in full)

12 AGE 68 Years Months Days If under 24 hours  
Hours Minutes

13 Usual Occupation Retired Ferry Captain  
(Kind of work done during most working life)

14 Industry or Business Ferryboat

15 Social Security No.  
16 BIRTHPLACE (City) East Boston  
(State or country) Mass

17 NAME OF FATHER James Kirley

18 BIRTHPLACE OF FATHER (City) Ireland  
(State or country)

19 MAIDEN NAME OF MOTHER Maria Murray

20 BIRTHPLACE OF MOTHER (City) Ireland  
(State or country)

21 Informant Marion Kirley  
(Address) 8 Atlantic St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:



SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....1-6-17.....

DATE OF DISCHARGE.....1-5-21.....

RANK, RATING .....Coxswain.....

ORGANIZATION AND OUTFIT.....U.S.Navy.....

SERVICE NUMBER.....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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PLACE OF DEATH

Suffolk

(County)

Winthrop

(City or Town)

No. Winthrop Community Hospital

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Pollock, X Harold H.  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence, No. 24 Beacon St. St. Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years 4 months 4 days. In place of residence 35 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec 18 1964  
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/18/64, 1964, to Dec 18, 1964

I last saw him alive on 12/18, 1964, death is said to have occurred on the date stated above, at 11:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion 4 days

(b) Atherosclerotic Disease 2 yrs

(c) Disease

OTHER SIGNIFICANT CONDITION: Chronic Asthma 8 yrs, RHEUMATOID ARTHRITIS 6 yrs

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) Charles Liberman M. D.  
(Print or Type Name)

(Address) Winthrop, Mass. Date 12/18/64

6 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL DEC 22 1964

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS Winthrop

Received and filed DEC 22 1964

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 238

(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Permanent Residence, No. 24 Beacon St. St. Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years 4 months 4 days. In place of residence 35 years months days.

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE 9 COLOR WHITE 10 SINGLE (write the word) MARRIED, WIDOWED, DIVORCED, UNKNOWN WIDOWED

11 If married, widowed, or divorced HUSBAND of ANGELINA FERPIO  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 60 Years Months Days If under 24 hours Hours Minutes

13 Usual Occupation TRUCK DRIVER  
(Kind of work done during most of working life)

14 Industry or Business FUEL

15 Social Security No.

16 BIRTHPLACE (City) NEWTON MASS  
(State or country)

17 NAME OF FATHER ALFRED POLLOCK

18 BIRTHPLACE OF FATHER (City) WESTWICK  
(State or country) CANADA

19 MAIDEN NAME OF MOTHER MARGARET (UNKNOWN)

20 BIRTHPLACE OF MOTHER (City) KILLYNEARY IRELAND  
(State or country)

21 Informant JAMES F CREEDEN

(Address) 22 IRWIN ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposedly due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 22 1964 PM



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## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD  
CERTIFICATE OF DEATH

Registered No. 161239

PLACE OF DEATH

SUFFOLK  
(County)WINTHROP  
(City or Town)

No. C 6 VIKING GARDENS

(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME HERMAN A BENSON

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, NO.  
if so specify WAR)(a) Permanent Residence. No. C 6 VIKING GARDENS St. WINTHROP  
(Usual place of abode) (City or town and State)

Length of stay: In place of death 1 years months days. In place of residence 35 years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 12 31 64  
(Month) (Day) (Year)4 I HEREBY CERTIFY That I attended deceased from  
SEP 15 64 to DEC 31 64I last saw him alive on DEC 31 64 death is said to  
have occurred on the date stated above, at 2 44 AM.DEATH WAS CAUSED BY: IMMEDIATE CAUSE  
CARCINOMA of COLONINTERVAL  
BETWEEN  
ONSET AND  
DEATH

3 1/2

(a) Due To

(b) Due To

(c) OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) EDWARD ROSEN, M. D.

16-4 St. STEVE REVERE

(Address) Date 12/31 1964

6 HOLY CROSS MALDEN  
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JAN 4 1965

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed DEC 31 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 9 COLOR 10 SINGLE (write the word)  
MALE WHITE MARRIED  
WIDOWED  
DIVORCED  
UNKNOWN MARRIED11 If married, widowed, or divorced  
HUSBAND of ANNA MORLEY  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 72 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation SALESMAN  
(Kind of work done during most of working life)

14 Industry or Business FOOD

15 Social Security No. 021-01-3539

16 BIRTHPLACE (City) EAST BOSTON  
(State or country) MASS

17 NAME OF FATHER SVEN BENSON

18 BIRTHPLACE OF FATHER (City) SWEEDEN  
(State or country)

19 MAIDEN NAME OF MOTHER ALMENA PETERSON

20 BIRTHPLACE OF MOTHER (City) SWEEDEN  
(State or country)

21 Informant MRS ANNA BENSON

(Address) C 6 VIKING GARDENS

I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianne (Nok)

(Signature of Agent of Board of Health or other)

Health Officer 12/31/64  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION.....  
 DATE OF ENTERING MILITARY SERVICE.....  
 DATE OF DISCHARGE.....  
 RANK, RATING.....  
 ORGANIZATION AND OUTFIT.....  
 SERVICE NUMBER.....  
 .....

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DEC 31 1964 PM



# COPY OF A RECORD OF DEATH

STATE FILE NO.

240

240

I HEREBY CERTIFY that the above is a true copy of information contained on the record of the death of the above named person which is in my official custody.

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Kennebec</u>				<b>2. USUAL RESIDENCE</b> Where deceased lived. If institution: residence before admission <b>a. STATE</b> <u>Mass.</u> <b>b. COUNTY</b> <u>Suffolk</u>			
<b>b. CITY, TOWN, OR LOCATION</b> <u>W. Vassar</u>		<b>c. LENGTH OF STAY IN 1b</b> <u>2 Wks.</u>		<b>c. CITY, TOWN, OR LOCATION</b> <u>Wintrop</u>			
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Home</u>				<b>d. STREET ADDRESS</b> (If rural give location) <u>105 Court Rd.</u>			
<b>e. IS PLACE OF DEATH IN RURAL AREA?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>e. IS RESIDENCE IN RURAL AREA?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>f. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3a. NAME OF DECEASED—First Name</b> <u>Frank</u>		<b>3b. Middle Name</b> 		<b>3c. Last Name</b> <u>Swansburg</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>10</u> Year <u>1964</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 18, 1907</u>		<b>9. AGE (In years last birthday)</b> <u>57</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done most of working life, even if retired) 		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fish Ind.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Shelburne, Nova Scotia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>W. H. Swansburg</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>W. H. Groveslain</u>		<b>15. NAME OF SPOUSE (If Married)</b> <u>Elizabeth Swansburg</u>			
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If yes, give war or dates of service)		<b>17. SOC. SECURITY NO.</b> <u>15-0-02</u>		<b>18. INFORMANT</b> <u>Elizabeth Swansburg, Father, Mass.</u>		<b>Address</b>	
<b>19. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Cerebral infarction of heart</u> Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. } <b>DUE TO (b)</b> <u>Death due to infarction</u> <b>DUE TO (c)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS</b> contributing to death but not related to the terminal disease condition given in Part I (a)						<b>20. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>21b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 19.) <u>Tractor Tipped over on him</u>					
<b>21c. TIME OF INJURY</b> <u>4:00PM</u>		<b>Hour</b> <u>a.m.</u> <b>Month, Day, Year</b> <u>Aug. 13, 1964</u>					
<b>21d. INJURY OCCURRED WHILE AT NOT WHILE WORK</b> <input checked="" type="checkbox"/> <b>AT WORK</b> <input type="checkbox"/>		<b>21e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Cottage</u>		<b>21f. CITY, TOWN, OR LOCATION</b> <u>W. Vassar</u> <b>COUNTY</b> <u>Kennebec</u> <b>STATE</b> <u>Maine</u>			
<b>22a. MEDICAL EXAMINER:</b> I hereby certify that death occurred at the time and from the causes stated above, and that I held an (investigation) (autopsy) on the remains of the deceased as required by law.				<b>22b. PHYSICIAN:</b> I hereby certify that I attended the deceased from to and last saw him alive on m. on the date and from the causes stated above.			
<b>23a. SIGNATURE</b> <u>L. D. Herring</u>		<b>(Degree or title)</b> <u>M.D.</u>		<b>23b. ADDRESS</b> <u>Wintrop, Mass.</u>		<b>23c. DATE SIGNED</b> <u>8/13/64</u>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>24b. DATE</b> <u>8/17/64</u>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodland Crematory</u>		<b>24d. LOCATION (City, town, or county) (State)</b> <u>Wintrop Massachusetts V.B.</u>	
<b>25. FUNERAL DIRECTOR</b> <u>Braddon &amp; Flanders, Wintrop, Mass.</u>		<b>ADDRESS</b> 		<b>26. DATE RECD. BY LOCAL REG.</b> <u>8/17/64</u>		<b>27. REGISTRAR'S SIGNATURE - A TRUE COPY, ATTEST:</b> <u>Mabel G. Smith</u>	

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PLACE OF DEATH

Suffolk  
(County)Boston  
(City or Town)

No.

Beth Israel Hosp.

Jacob M. Cohen

2 FULL NAME

COHEN Jacob

(If deceased is a married, widowed or divorced woman, give also maiden name.)

38 Trident Avenue

(a) Permanent Residence. No.  
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 1 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from  
11/21, 1964, to 12/1/64, 1964I last saw him alive on 12/1/64, 1964, death is said to  
have occurred on the date stated above, at 10:55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Sudden death 5th day post op.

Due To ? Heart Failure

(b) Gen. arteriosclerosis

(c) Hypertension

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) F. Merhav M. D.

A. MERHAV  
(Print or Type Name)

(Address) BETH 330 Brookline Ave. Date 12/1/64

6 Anshe-Poland (Montvale) Woburn

Place of Burial or Cremation (City or Town)

Kenesseth Israel, December 2, 1964

DATE OF BURIAL

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed DEC 7 1964

William J. Kane

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATH

Registered No.

(City or Town making this return)

241  
11611(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran, no  
if so, specify WARI.  
Winthrop, Mass.  
(City or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX male 9 COLOR white 10 SINGLE (write the word)  
MARRIED  
WIDOWED widowed  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Rose Lurensky  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 84 Years Months Days If under 24 hours  
Hours Minutes13 Usual Occupation Dry Goods (retired)  
(Kind of work done during most of working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City). Lithuania  
(State or country)

17 NAME OF FATHER Joel I. Cohen

18 BIRTHPLACE OF FATHER (City). Lithuania  
(State or country)

19 MAIDEN NAME OF MOTHER (unknown)

20 BIRTHPLACE OF MOTHER (City). Lithuania  
(State or country)21 Informant Maurice Cohen  
5015 Circle Road, Montreal, Canada  
(Address)I HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation)

(Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*

City Registrar



R-301

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OUT - OF - TOWN

Suffolk  
(County)Boston  
(City or Town)

No. New England Center Hospital

2 FULL NAME **Walter  
Albert Howe**  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. **42 Floyd Street** St. **Winthrop, Mass.**

6

Length of stay: In place of death.....years.....months.....days. In place of residence **35** years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH **December 2 1964**  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased, from  
**November 26, 1964, to December 2, 1964**I last saw him on **December 2, 1964**, death is said to  
have occurred on the date stated above, at **6:40 a.m.**

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) **Acute Myocardial Infarction**INTERVAL  
BETWEEN  
ONSET AND  
DEATH**6 days**

Due To

(b)

Due To

(c)

OTHER  
SIGNIFICANT  
CONDITIONS **Congestive Heart Failure  
Hypertension**Was autopsy performed? **yes**What test confirmed diagnosis? **electrocardiogram**5 Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify(Signature) **Jack N. Albert**, M. D.(Address) **33 Oak St. Boston** Date **12/2/64**6 **Sand Hill Cemetery, Dickinson, N.Y.**  
Place of Burial or Cremation (City or Town)DATE OF BURIAL **December 5, 1964**7 NAME OF FUNERAL DIRECTOR **Alfred B. March**ADDRESS **174 Winthrop St. Winthrop,**Received and filed **DEC 7 1964****William J. Kane**

(Registrar)

The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATH

Registered No.

11681

{(If death occurred in a hospital or institution,  
St. give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

{(Was deceased a  
U. S. War Veteran,  
if so specify WAR) NO.

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX **male** 9 COLOR **white** 10 SINGLE (write the word)  
MARRIED **widowed**  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of **Dorothy Marshall**  
(Give maiden name of wife in full)(or) WIFE of.....  
(Husband's name in full)12 **56** AGE **66** Years **9** Months **15** Days  
If under 24 hours  
Hours.....Minutes13 Usual Occupation.....**civillian auditor**  
(Kind of work done during most of working life)14 Industry or Business.....**U.S. Navy**15 Social Security No. **140-07-2474**16 BIRTHPLACE (City).....**Moiri**  
(State or country) **New York**17 NAME OF FATHER **Walter Howe**18 BIRTHPLACE OF FATHER (City).....**Waverly**  
(State or country) **New York**19 MAIDEN NAME OF MOTHER **Emma Snyder**20 BIRTHPLACE OF MOTHER (City).....**Bombay**  
(State or country) **New York**21 Informant **Joseph H. Lyon**  
(Address) **Moiri, New York**I HEREBY CERTIFY that a satisfactory standard certificate of death  
has been filed with me BEFORE the burial or transit permit was issued:**Walter Terroni**  
(Signature of Agent of Board of Health or other)**13-3-64**  
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*

City Registrar

R-301

Burial permit  
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OUT - OF - TOWN

SUFFOLK

BOSTON

PLACE OF DEATH

(County)

(City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL

2 FULL NAME Leonard Mazzarella  
(If deceased is a married, widowed or divorced woman, give also maiden name.)(a) Permanent Residence. No. 101 Leyden  
(Usual place of abode)Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5 1964  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from  
Dec 4, 1964, to Dec 5, 1964I last saw him alive on Dec 5, 1964. Death is said to  
have occurred on the date stated above, at 3:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ACUTE MYOCARDIAL INFARCT

(b) Due To CORONARY HEART DISEASE

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONSWas autopsy performed? YES YESWhat test confirmed diagnosis? AUTOPSY5 Was disease or injury in any way related to occupation of deceased?  
If so, specify C.C. Clay(Signature) Charles L. Clay, M.D., M. D.(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date 12 5 19646 Winthrop Winthrop  
Place of Burial or Cremation (City or Town)DATE OF BURIAL Dec 9, 19647 NAME OF FUNERAL DIRECTOR Ernest P. PagnanoADDRESS 147 Winthrop St Winthrop MassReceived and filed DEC 11 1964 19

(Registrar)

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICSSTANDARD  
CERTIFICATE OF DEATHRegistered No. 11874(If death occurred in a hospital or institution,  
give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

(Was deceased a  
U. S. War Veteran, WWII  
if so specify WAR)St. E Boston  
(City or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word)  
MARRIED  
WIDOWED single  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of (Give maiden name of wife in full)  
(or) WIFE of (Husband's name in full)12 AGE 61 Years 7 Months 9 Days  
If under 24 hours  
Hours.....Minutes13 Usual Occupation Taxi Driver  
(Kind of work done during most of working life)14 Industry or Business Taxi15 Social Security No. 0 23-16-415816 BIRTHPLACE (City) Boston  
(State or country) Mass17 NAME OF FATHER Francesco Mazzarella18 BIRTHPLACE OF FATHER (City) Italy  
(State or country)19 MAIDEN NAME OF MOTHER Filomena Vacca20 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)21 Informant Mrs Lena Marotta  
(Address) 101 Leyden St E BostonI HEREBY CERTIFY that a satisfactory standard certificate of death  
was filed with me BEFORE the burial or transfer permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) 5873 (Date of Issue of Permit) 12-5-64

243

(City or Town making this return)



A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar



JAN 22 1905 AM

## The Commonwealth of Massachusetts

KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS

Revere

(City or Town making this return)

PLACE OF DEATH

Suffolk

(County)

Revere

(City or Town)

Grover Manor Hospital

No.

COPY OF

## CERTIFICATE OF DEATH

Registered No. 244

(If death occurred in a hospital or institution,  
St. { give its NAME instead of street and number)

Ethel Anderson (Hubbard)

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a  
U. S. War Veteran, No  
if so specify WAR)

24 Orlando Avenue

x  
St.

Winthrop

(a) Residence. No.  
(Usual place of abode)

3

35

(City or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6, 1964  
(Month) (Day) (Year)I HEREBY CERTIFY that I attended deceased from  
Dec. 3, 1964, to Dec. 6, 1964.  
I last saw her alive on Dec. 6, 1964, at 1:10 P.M.  
death is said to  
have occurred on the date stated above, at .....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia

(b) Due To Myocardial infarction

(c) Due To

OTHER  
SIGNIFICANT  
CONDITIONS

No

Was autopsy performed? Clinical Signs

What test confirmed diagnosis? No

5 Was disease or injury in any way related to occupation of deceased?  
If so, specify

James F. Burns

(Signature) ..... M. D.

405 Washington Ave. 12/7 64  
(Address) Revere Date 19

Woodlawn Crematory Everett

6 Place of Burial or Cremation December 8, 1964  
(City or Town)7 NAME OF DIRECTOR Alfred B. Marsh  
FUNERAL 174 Winthrop St., Winthrop

ADDRESS JAN 12 1965

Received and filed 19

(Registrar of City or Town where deceased resided)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female 9 COLOR White 10 SINGLE (write the word)  
MARRIED Widowed  
WIDOWED  
DIVORCED  
UNKNOWN11 If married, widowed, or divorced  
HUSBAND of Charles Anderson (Husband's name in full)  
(or) WIFE of .....  
(Give maiden name of wife in full)12 AGE 95 Years 11 Months 7 Days If under 24 hours  
Hours Minutes13 Usual Occupation: Housewife  
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. Lowell

16 BIRTHPLACE (City) Mass.  
(State or country)

17 NAME OF FATHER Henry Ellsworth Hubbard

18 BIRTHPLACE OF FATHER (City) Sullivan  
(State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Sophia Stoughton

20 BIRTHPLACE OF MOTHER (City) Roxbury  
(State or country) Vermont

21 Informant Mrs. Elizabeth E. Siass

24 Orlando Ave., Winthrop  
(Address)

A TRUE COPY

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED December 10, 1964

SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

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#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

---

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

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**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.



OUT - OF - TOWN

The Commonwealth of Massachusetts

R-301

Suffolk  
(County)Boston  
(City or Town)KEVIN H. WHITE  
SECRETARY OF THE COMMONWEALTH  
DIVISION OF VITAL STATISTICS245  
(City or Town making this return)STANDARD  
CERTIFICATE OF DEATH

Registered No. 11992

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John N. MC DONALD  
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR Korean)

(a) Permanent Residence. No. 199 Winthrop St. Winthrop, Mass.  
(Usual place of abode) (City or town and State)

Length of stay: In place of death, years 2 months 3 days. In place of residence, years months days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10 1964  
(Month) (Day) (Year)4 I HEREBY CERTIFY, That I attended deceased from October 7, 1964, to December 10, 1964.  
~~XXXXXXXXXXXXXXXXXXXX~~ death is said to have occurred on the date stated above, at 3:40 p.m.INTERVAL  
BETWEEN  
ONSET AND  
DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary atelectasis

mos.

(b) Hodgkins Disease

yrs.

(c)

OTHER  
SIGNIFICANT  
CONDITIONS

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signature) Stewart Wright, M. D.

(Address) VAH/Boston, Mass. Date Dec. 11 1964

Winthrop Cem., Winthrop, Mass.

6 Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 14 1964

7 NAME OF FUNERAL DIRECTOR Kirby Funeral Home

ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed DEC 15 1964

(Registrar)

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male 9 COLOR White 10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Barbara Bryant  
(Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE 32 Years 9 Months 26 Days If under 24 hours Hours Minutes

13 Usual Occupation Electronic Tech.  
(Kind of work done during most of working life)

14 Industry or Business 017 24 4118

15 Social Security No.

16 BIRTHPLACE (City) Waltham  
(State or country) Mass.

17 NAME OF FATHER John Mc Donald

18 BIRTHPLACE OF FATHER (City) Nova Scotia  
(State or country) Canada

19 MAIDEN NAME OF MOTHER Cecelia Welsh

20 BIRTHPLACE OF MOTHER (City) Brighton  
(State or country) Mass.21 Informant V.A. Hospital Records  
150 S. Huntington Ave.  
(Address) Boston 30, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

05958  
(Official Designation)12-11-64  
(Date of Issue of Permit)

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

PLACE OF DEATH

BRISTOL

(County)  
FALL RIVER

(City or Town)

AT NORTH PARK OPPOSITE BELMONT

No.

JOSEPH ANDERSON

2 FULL NAME

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No.

472 142 WINTHROP ST.

(Usual place of abode)

St.

WINTHROP, MASS.

(If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

## MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH

DECEMBER

21

1964

(Month)

(Day)

(Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

MULTIPLE FRACTURES WITH INTERNAL HEMORRHAGE

ACCIDENT

12/21/64

5 Accident, suicide, or homicide (specify)

YES

Date and hour of injury

FALL RIVER, MASS.

19

Where did injury occur?

HIGHWAY (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place?

CAB OF TRUCK H.I.T. TREE (Specify type of place)

Manner of injury

MULTIPLE FRACTURE &amp; INTERNAL HEMORRHAGE (Specify injury occur?)

Nature of injury

YES

While at work? Was autopsy performed?

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

RAYMOND R. COSTA

(Signed)

M. D.

(Address)

610 BRADFORD AVE.

DATE

12/21/64

19

7 WINTHROP CEM.

WINTHROP, MASS.

Place of Burial, or Cremation.

(City or Town)

DATE OF BURIAL

DECEMBER 24, 1964

19

8 NAME OF FUNERAL DIRECTOR

ERNEST P. CAGGIANO

ADDRESS

147 WINTHROP ST., WINTHROP, MASS.

Received and filed

19

(Registrar of City or Town where deceased resided)

## The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY  
DIVISION OF VITAL STATISTICS  
COPY OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

FALL RIVER

246

(City or town making return)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(Was deceased a U. S. War Veteran, if so specify WAR)

WW-11

St. WINTHROP, MASS.

(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

9 SEX

10 COLOR OR RACE

11 SINGLE (write the word)

MARRIED

WIDOWED

or DIVORCED

MALE

WHITE

MARRIED

11a If married, widowed, or divorced

HUSBAND of ALICE T. ADAMSON

(Give maiden name of wife in full)

(or) WIFE of

(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13

AGE

Years

Months

TRUCK DRIVER

Days

If under 24 hours

Hours

Minutes

14 Usual Occupation

1

(Kind of work done during most of working life)

15 Industry or Business

16 Social Security No.

WINTHROP, MASS.

17 BIRTHPLACE (City)

(State or country)

JOSEPH ANDERSON

18 NAME OF FATHER

19 BIRTHPLACE OF

FATHER (City)

(State or country)

CHRISTINE UNGER

20 MAIDEN NAME OF MOTHER

21 BIRTHPLACE OF

NORWAY

MOTHER (City)

(State or country)

ALICE T. ANDERSON

22

Informant

(Address)

472

142 WINTHROP ST., WINTHROP, MASS.

A TRUE COPY.

ATTEST:

(Registrar of City or Town where death occurred)

DATE FILED

1/12/65

19

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

01365

U.A.V.



SPACE FOR ADDITIONAL INFORMATION.....  
DATE OF ENTERING MILITARY SERVICE.....  
DATE OF DISCHARGE.....  
RANK, RATING.....  
ORGANIZATION AND OUTFIT.....  
SERVICE NUMBER.....  
.....

---

#### RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

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(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

---

**Statement of Cause of Death.**—Physicians: see explanatory instructions on face side of standard certificate of death.

---

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

PLACE OF DEATH

Suffolk  
(County)Boston  
(City or Town)

No. Boston City Hospital

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gennaro Scarafone

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT  
(Was deceased a  
U. S. War Veteran,  
if so specify WAR) W.W.1

(a) Residence. No. 148 Bartlett Rd.

St.

Ward

Winthrop

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

days. How long in U. S., if of foreign birth?

yrs.

mos.

days.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male  
4 COLOR white  
5 SINGLE (write the word) MARRIED Widowed  
WIDOWED or DIVORCED

5a If married, widowed, or divorced  
HUSBAND of Margaret Mastercusio  
(Give maiden name of wife in full)  
(or) WIFE of  
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years Months Days  
If less than 1 day Hours Minutes

9 Occupation: Usual Weaver

10 Industry or Business: retired

11 Social Security No. 024-07-2332

12 BIRTHPLACE (City) Italy  
(State or country)

13 NAME OF FATHER Domenic Scarafone

14 BIRTHPLACE OF FATHER (City) Italy  
(State or country)

15 MAIDEN NAME OF MOTHER C.N.P.L.

16 BIRTHPLACE OF MOTHER (City) Italy  
(State or country)

17 Informant Rose M. Renoni (daughter)  
(Address) 148 Bartlett Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Signature of Agent of Board of Health or other  
Official Designation

(Date of Issue of Permit)

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 29 1964  
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE and MANNER thereof are as follows:  
(If an injury was involved, state fully.)

Fracture of skull

Auto-accident

Pedestrian

Boston 12-28-64

20 IN WHAT CITY OR TOWN WAS INJURY SUSTAINED?

(Signed)

(Address)

M. D.

12-29-64

Date 19

21 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Malden  
(Cemetery) (City or town)

DATE OF BURIAL December 31, 1964

22 NAME OF UNDERTAKER Frederick J. Magrath  
ADDRESS East Boston

Received and filed

JAN 5 1965

19

Signature of Registrar

(Registrar)

A TRUE COPY ATTEST:

*William J. Kane.*  
City Registrar

RECEIVED



JAN 27 1965 AM











